

338154

DIVISION OF VITAL RECORDS, 201 W. PRINCE ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE SPACE PROVIDED. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER SLIP. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRINCE STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>Robert James ALTON</b>						2a. DATE KNOWN OF DEATH ESTIMATED <b>Nov 16 1985</b>		2b. HOUR <b>A</b>		2c. DATE PRONOUNCED DEAD <b>Nov 16 1985</b>		2d. HOUR <b>1:45 P</b>							
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8-12-1939</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>46 YRS.</b>		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON</b>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.Y.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>41 1/2 E. FRANKLIN ST</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>SYSTEMS ANALYST</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>FLORIDA</b>				13b. COUNTY				13c. CITY OR TOWN <b>TITUSVILLE</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <b>305 ROSE MARIE DR</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>ROBERT G ALTON</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CATHERINE COWEN</b>						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO.			
17. INFORMANT <b>FRANCES McALEE</b>						ADDRESS <b>SAME AS 13</b>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>upper G.I. Hemorrhage, ulcerative disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>ALCOHOLISM</b> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>444</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>Alcoholism</b>																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <b>H. N. Weeks</b>				TITLE (SPECIFY) <b>Rep</b>				M.D. <b>Rep</b>				MEDICAL EXAMINER <b>Rep</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>H. N. Weeks</b>				ADDRESS <b>80 North Ave Hagerstown MD</b>				DATE SIGNED <b>Nov 17 1985</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>				23b. DATE <b>11/19/85</b>				23c. NAME OF CEMETERY OR CREMATORY <b>SMITHSBURG CREMATORIUM</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>SMITHSBURG WASH. MD</b>							
24. FUNERAL DIRECTOR NAME <b>Kulhan</b>				ADDRESS <b>Thore Hancock MD</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 02 1985</b>				25b. REGISTRAR'S SIGNATURE <b>Julian Swickard</b>							

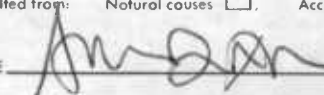
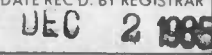
61836

308188

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>CHRISTY SHARON BABINGTON</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED MONTH <b>11</b> DAY <b>24</b> YEAR <b>1985</b>			2b. HOUR M <b>AM</b>			
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>July</b> DAY <b>5</b> YEAR <b>1942</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. <b>43</b>	IF UNDER 1 YR. MONTHS <b>43</b> DAYS <b>43</b> HOURS <b>43</b> MIN <b>43</b>	7c. DATE PRONOUNCED DEAD MONTH <b>11</b> DAY <b>24</b> YEAR <b>1985</b>				7d. HOUR PM <b>6:10</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Keedysville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rt. 1, Box 277, Dogstreet Rd.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		
13a. STATE <b>Md.</b>		13b. CITY OR TOWN <b>Washington Keedysville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 1 Dog St. 20825</b>			
14. FATHER'S NAME FIRST <b>E.</b> MIDDLE <b>S.</b> LAST <b>CONWAY</b>				15. MOTHER'S MAIDEN NAME FIRST <b>VIRGINIA</b> MIDDLE <b>MARSHALL</b> LAST <b>MARSHALL</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>213-40-6834</b>		17. INFORMANT <b>Robert Babington Keedysville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Perforating gunshot wound of head (rifle)</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? <b>Head Only</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOURS <b>4</b> MIN <b>PM</b> MONTH <b>11</b> DAY <b>24</b> YEAR <b>1985</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Self-inflicted.</b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>		21f. LOCATION STREET <b>Rt. 1, Box 277, Dogstreet Rd.</b> CITY OR TOWN <b>Keedysville</b> COUNTY <b>Washington</b> STATE <b>MD</b>				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE 			TITLE (SPECIFY) <b>M.D. Assistant</b>			DATE SIGNED <b>11-25-85</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>			ADDRESS <b>111 Penn St., Balto., MD 21201</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Nov. 27, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Keedysville</b> COUNTY <b>Wash.</b> STATE <b>Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Thompson Funeral Home</b> ADDRESS <b>Middletown, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>DEC 2 1985</b>		25b. REGISTRAR'S SIGNATURE 				

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. WITH PAGES 1, 2, AND 3, RETAIN PAGE 5 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER AND TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

321113

UNITED STATES

Female, White, July 1, 1912-13

New York, N.Y.

born [unclear] own home

Oct. 1, 1912

Washington, D.C.

10

Married

VIETNAM

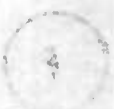
COMBAT

3

2

213-40-5534 Robert Robinson, E. 100-1111-10

No



Nov. 2, 1962, at New York, N.Y. 100-1111-10

Nov. 2, 1962

100-1111-10, 100-1111-10



322051

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 2 5 8 2

1. FOR STATE REGISTRAR		REG. NO.	
2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST David Earl Bachtell		2a. DATE OF DEATH MONTH DAY YEAR 11 05 85	
3. SEX Male		2b. HOUR 7:35p M	
4. RACE White		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
5. DATE OF BIRTH MONTH DAY YEAR 11 11 12		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WESTERN MARYLAND CENTER	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farm	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Washington	
13c. CITY OR TOWN Smithsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE Rt. 2, Box 401 21783			
14. FATHER'S NAME FIRST MIDDLE LAST Earl Bachtell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virgie Dayhoff	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 215-36-6563	
17. INFORMANT ADDRESS Mrs. Nina M. Bachtell Smithsburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one hour	
DUE TO, OR AS A CONSEQUENCE OF (b) Parkinson's Disease		Years	
DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10-21, 19 85, to 11-5, 19 85, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11-5, 19 85, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> view the body after death.			
22b. SIGNATURE Kyung S. Kim, M.D.		22c. DATE SIGNED 11-5-85	
22d. ADDRESS 1500 Pennsylvania Avenue Hagerstown, MD 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 8, 1985	
23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		23d. LOCATION City or Town County State Smithsburg, Wash., Md.	
24. FUNERAL DIRECTOR Davis Funeral Home Smithsburg, Md.		25a. DATE REC'D. BY REGISTRAR NOV 12 1985	
25b. REGISTRAR'S SIGNATURE			

BP

for

25

25-25

11-11

11-11



322003

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert this certificate in the envelope and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other required information, the medical examiner must be notified on page 4.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SARAH ELIZABETH BATT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11/7/85</b>			2b. HOUR MIN. <b>7:45</b> M				
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>October 25, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.		6. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>7</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Hagerstown</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.				
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Fair Play</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Route 1, Box 22 21733</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Valentine</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine Huber</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-09-5397</b>		17. INFORMANT ADDRESS <b>Russell P. Batt, Fair Play, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>hemiparesis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>		
								<u>stroke</u>		
								<u>years</u>		
								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Heart Disease</u>		
19a. DATE OF OPERATION <u>10/1/85</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Dehydration, hypotension, cerebral arteriosclerosis, returning clots</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>10/1/85</u> , 19 <u>85</u> , to <u>11/7/85</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>11/6/85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Edson B. Moody</u>			DEGREE <u>MD</u>			22c. DATE SIGNED <u>11/1/85</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Edson B. Moody</u>			22e. ADDRESS <u>Rt #3 Box 163 Hagerstown, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL SPECIES <b>burial</b>			23b. DATE <b>Nov. 11, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mark's Epis. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lappans Cross., Hag., Wash., Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</b>						25a. DATE REC'D. BY REGISTRAR <b>Nov 12 1985</b>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

BP

330003



UNITED STATES DEPARTMENT OF AGRICULTURE

RECEIVED COTTON LIBRARY

THE UNIVERSITY OF CALIFORNIA

LIBRARY OF THE UNIVERSITY OF CALIFORNIA

LIBRARY OF THE UNIVERSITY OF CALIFORNIA

LIBRARY OF THE UNIVERSITY OF CALIFORNIA

LIBRARY OF THE UNIVERSITY OF CALIFORNIA

LIBRARY OF THE UNIVERSITY OF CALIFORNIA

LIBRARY OF THE UNIVERSITY OF CALIFORNIA

337057

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Franklin A. Bell</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 17 1985</b>		2b. HOUR <b>4:30 P.</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 25 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Area Office Mgr.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Electric Power</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Hagerstown</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank D. Bell</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine Strite</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>211-10-4626</b>		17. INFORMANT ADDRESS <b>R. D. 5 Box 314 Hagerstown, Md. 21740</b>	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Recurrent pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>10-29</b> , 19 <b>85</b> , to <b>11-17</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>11-17</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Eric M. Wagshal</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-17-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Eric M. Wagshal</b>		22e. ADDRESS <b>1825 Howell Rd., Hagerstown, Md. 21740</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11/20/1985</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Leitersburg Lutheran</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Leitersburg Washington Md.</b>	
24. FUNERAL DIRECTOR NAME <b>David K. K...</b>		50 S. Broad St. Waynesboro, Penna.		25. DATE REC'D. BY REGISTRAR <b>NOV 26 1985</b>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

37003

FILED



RECEIVED  
FBI  
JAN 11 1982

1982 JAN 17 10:30

1982 JAN 17 10:30

1982 JAN 17 10:30

1982 JAN 17 10:30

1982 JAN 17 10:30

1982 JAN 17 10:30

1982 JAN 17 10:30

1982 JAN 17 10:30

1982 JAN 17 10:30

1982 JAN 17 10:30

1982 JAN 17 10:30

1982 JAN 17 10:30

1982 JAN 17 10:30

1982 JAN 17 10:30

1982 JAN 17 10:30

1982 JAN 17 10:30

1982 JAN 17 10:30

1982 JAN 17 10:30

1982 JAN 17 10:30

1982 JAN 17 10:30

323094

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
		FIRST May		MIDDLE F.		LAST Bent		11-13-85		11:30 AM	
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR		7. IF UNDER 24 HRS	
Female		Caucasian		MONTH 6 19 1884		101		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
S. D.		USA				Washington MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		1110 Sherman Avenue						housewife			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		21740	
Maryland		Washington		Hagerstown		YES <input type="checkbox"/> NO <input type="checkbox"/>		1110 Sherman Ave.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Joseph Platt				FIRST MIDDLE LAST Susan Smith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				705-10-6774D		Neva Shannon, Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Chronic renal failure										months	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR							
				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11-18-72, 19 to present 19, that (I) (we) last saw the deceased alive on 11/11/85, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
				M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				11-13-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Charles C. Spencer, M.D.				1198 Kenly Avenue; Hagerstown, Md. 21740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
burial				Nov. 15, 1985		Rest Haven Cem.		Hagerstown, Wash., Maryland			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
NAME MINNICH FUNERAL HOME ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740				NOV 18 1985				John Davidson-Rendell			



SEX COLON LIB

338201

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Margaret H. Bittner</i>			2a DATE OF DEATH MONTH DAY YEAR <i>11 16 85</i>		2b HOUR <i>6 AM</i>						
1 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>March 27, 1905</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>80</i> YRS.		7 IF UNDER 1 YEAR MONTHS DAYS <i>11 16</i>		8 IF UNDER 24 HRS HOURS MIN. <i>6 AM</i>	
10 BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Washington Co.</i> MD.					
10 CITY OR TOWN OF DEATH <i>Hagerstown</i>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Teacher</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Public Schools</i>			
13a STATE <i>Md.</i>			13b COUNTY <i>Washington</i>		13c CITY OR TOWN <i>Hagerstown</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <i>R.D.#9 Box 151 21740</i>		
14 FATHER'S NAME FIRST MIDDLE LAST <i>George Frank Hartle</i>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Odesa Myers</i>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b SOCIAL SECURITY NO. <i>572-28-0952</i>			17 INFORMANT ADDRESS <i>Mr. Roger Eshelman 1022 Potomac Ave. Hagerstown, Md. 21740</i>					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertensive CVD</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 hrs</i> <i>11</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>0</i>											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE <i>Hagerstown, Md.</i>					
22a I certify that (I) (this hospital) attended the deceased from <i>14 July 1982</i> to <i>15 Nov 1985</i> that (I) (we) last saw the deceased alive on <i>15 Nov 1985</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (above) (I) (we) (did not) (saw) the body after death											
22b SIGNATURE <i>Richard C. Bittner</i>			DEGREE <i>MD</i>			22c DATE SIGNED <i>16 Nov 85</i>					
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Bittner</i>			22e ADDRESS <i>Hagerstown, Md.</i>								
23a BURIAL, CREMATION, REMOVAL (CHECK ONE) <i>Burial</i>			23b DATE <i>11/19/85</i>			23c NAME OF CEMETERY OR CREMATORY <i>Green Hill Cemetery</i>			23d LOCATION CITY OR TOWN COUNTY STATE <i>Waynesboro, Franklin Pa.</i>		
24 FUNERAL DIRECTOR NAME <i>John J. ...</i>			ADDRESS <i>50 S. Broad St. Waynesboro, Pa. 17268</i>			25a DATE REC'D. BY REGISTRAR			25b REGISTRAR'S SIGNATURE <i>Robert ...</i>		

BP



322005

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Alma Bowman</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>Nov 3 85</b>		2b. HOUR <b>5:45 M</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 13, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.
10. CITY OR TOWN OF DEATH <b>Williamsport</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Williamsport Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Hagerstown</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Eli Martin</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucy Weaver</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>024-18-4718</b>		17. INFORMANT ADDRESS <b>Walter E. Bowman same as 13</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Pulmonary edema</b>				
19a. DATE OF OPERATION ____		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ____		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ____ P.M. _____ 19 <b>85</b>		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) ____		21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) ____		21f. LOCATION STREET CITY OR TOWN COUNTY STATE ____		
22a. I certify that (I) (this hospital) attended the deceased from <b>11-3</b> 19 <b>85</b> to <b>11-3</b> 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>11-3</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.				
22b. SIGNATURE <b>Max E. Byrkit</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-3-85</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Max E. Byrkit</b>		22e. ADDRESS <b>Williamsport Md</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-6-85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery Hagerstown Wash. Md.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>NOV 12 1985</b>		
24. FUNERAL DIRECTOR NAME <b>Gerald N. Minnich</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 12 1985</b>		
25b. REGISTRAR'S SIGNATURE <b>Gerald N. Minnich</b>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/B1  
(VRA 15, 4)

Nov 8 1952

Nov 11 1952

Information - (1) The report of the ...  
... (2) The report of the ...  
... (3) The report of the ...

... (4) The report of the ...  
... (5) The report of the ...  
... (6) The report of the ...

... (7) The report of the ...  
... (8) The report of the ...  
... (9) The report of the ...

... (10) The report of the ...  
... (11) The report of the ...  
... (12) The report of the ...

... (13) The report of the ...  
... (14) The report of the ...  
... (15) The report of the ...

... (16) The report of the ...  
... (17) The report of the ...  
... (18) The report of the ...

... (19) The report of the ...  
... (20) The report of the ...  
... (21) The report of the ...

... (22) The report of the ...  
... (23) The report of the ...  
... (24) The report of the ...

3

331091

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>William McKinley Brewbaker, Jr.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>November 19, 1985</i>			2b. HOUR M <i>AM</i>	
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>April 12, 1921</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>64</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.	
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>supervision</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>railroad</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>				13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>2311 Indian Cottage Road</i>		13f. ZIP CODE <i>21740</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>William M. Brewbaker</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ida Celia Baer</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>Yes W.W.II</i>		16b. SOCIAL SECURITY NO. <i>705-14-0137</i>	
17. INFORMANT <i>Anna Brewbaker, Hagerstown, Md.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Atherosclerotic Coronary Artery Disease</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i></i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>19 Nov.</i> , 19 <i>85</i> , to <i>19 Nov.</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>William Noel Fender M.D.</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>21 Nov. 1985</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Wm. Noel Fender M.D.</i>		22e. ADDRESS <i>138 E. Antietam St., Hagerstown, MD.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b. DATE <i>Nov. 22, 1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Lawn Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown, Wash., Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>MINNICH FUNERAL HOME</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 25 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Gabe Gordon-Randall</i>	
415 E. Wilson Blvd., Hagerstown, Md. 21740							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copy 4 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

331031





326025

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate must be filed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Ruth Laign BUTTS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11/7/85</b>		2b. HOUR <b>5:20p M</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 30, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Ravenwood Luthren Home</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Hagerstown</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1656 Lauren Road 21740</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Morgan V. Laign</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret A. Pearrell</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-74-2892</b>		17. INFORMANT ADDRESS <b>Gerald L. Butts 19 Oak Lane Sterling, Va.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute pneumonia, LU</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <b>recurrent CVA</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>1 mo</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Ascua</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>11-83</b> to <b>11-85</b> , that (I) (we) last saw the deceased alive on <b>11-85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>[Signature]</b>			22c. DATE SIGNED <b>11-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. B. KANG, M.D.</b>		22e. ADDRESS <b>1933 Va Ave, Hagerstown, MD</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-11-85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery Hagerstown Wash. Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Gerald N. Minnich Hagerstown, Maryland</b>		305 N. Potomac St.		25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1985</b>		
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)



326091

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Florence Viola CASTLE			2a. DATE OF DEATH MONTH DAY YEAR November 18, 1985		2b. HOUR M						
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR June 6, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY aircraft			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10 Downsville Road 21740			
14. FATHER'S NAME FIRST MIDDLE LAST Tryon E. Bragunier						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie L. Rice					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Betty V. Eshelman, Hagerstown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular accidents</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic cardiovascular disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from _____, 19____, to <u>11/18</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>11/17</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE <u>George Newman II</u>						DEGREE M.D.			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE Nov. 20, 1985		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740						25a. DATE REC'D. BY REGISTRAR NOV 20 1985			25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper to page 4 and 5 and 7 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

1800300

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1 - STATE  
REGISTRAR

REG. NO.

319115

1. DECEASED NAME (TYPE OR PRINT) <i>Ruth</i>		FIRST <i>P.</i>		MIDDLE <i>Chapman</i>		LAST		2a. DATE OF DEATH MONTH DAY YEAR <i>11-4-85</i>				2b. HOUR <i>10:55 P.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Dec. 6 1895</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>89</i>				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington County</i> MD.							
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Garlock Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Teacher</i>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i>				13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>540 N. Locust St. 21740</i>			
14. FATHER'S NAME FIRST <i>Seldon</i> MIDDLE <i>NMN</i> LAST <i>Pollard</i>				15. MOTHER'S MAIDEN NAME FIRST <i>Margretta</i> MIDDLE <i>NMN</i> LAST <i>Johnson</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <i>No</i>				16b. SOCIAL SECURITY NO. <i>225-42-3333</i>		17. INFORMANT ADDRESS <i>Marguerite Doleman 540 N. Locust St.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio sclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Duchenne's Myelitis - Post op malingering</i>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>11/3</i> , 19 <i>85</i> , to <i>11/4</i> , 19 <i>85</i> , that (I) (we) lost saw the deceased alive on <i>11/3</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>E. Hoachler</i>				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>11/5/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>E. Hoachler</i>				22e. ADDRESS <i>Hagerstown Md</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>11/8/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Mem. Cem</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Portsmouth Norfolk Va.</i>			
24. FUNERAL DIRECTOR NAME <i>Norris L. Davis</i> ADDRESS <i>Smithburg, Md. 21783</i>				25a. DATE REC'D. BY REGISTRAR <i>11/08/85</i>				25b. REGISTRAR'S SIGNATURE <i>Julia K. ...</i>					

MEDICAL CERTIFICATION

H



312031

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

32592

1. DECEASED NAME (TYPE OR PRINT) <b>Noah E CHURCHEY</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>November 2, 1985</b>		2b. HOUR MIN. <b>6:50 P.M.</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>September 14, 1899</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>maintenance</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Children Home</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1029 Pope Avenue 21740</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Noah W. Churchey</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Bracheers</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-16-0566</b>		17. INFORMANT ADDRESS <b>Mrs. Virginia Trimmer, Smithsburg, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute massive CVA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>1 week years</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetes Mellitus</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1980</b> to <b>11-2</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>11-2</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (shall) (did not) view the body after death.					
22b. SIGNATURE <b>W. T. Kang, M.D.</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4-3-86</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>Nov. 5, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sharpsburg, Wash., Maryland</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>MINNICH FUNERAL HOME 415 East Wilson Blvd., Hagerstown, Maryland 21740</b>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>NOV 06 1985</b>	

BP  
DHMH - 16 50M 4/83  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove the earlier pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.



1000

THE NEW YORK PUBLIC LIBRARY

324118

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Oscar L. Clark</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11 12 85</b>		2b. HOUR <b>4<sup>30</sup> P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 08 1900</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>85</b> YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>construction</b>			
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Washington</b>		13c. STREET ADDRESS / ZIP CODE <b>104 N. Cleveland Ave. 21740</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Phillip Clark</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Belle Luttrell</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>216-14-6367</b>		17. INFORMANT ADDRESS <b>Mildred Clark, Hagerstown, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Renal failure acute</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Aortic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>&lt; 24 h</b> <b>&lt; 48 h</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <b>Arrhythmia - Congestive Heart Failure Atrial Fibrillation</b>					
19a. DATE OF OPERATION <b>11-13-85</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Heart Failure</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>11-27</b> , 19 <b>85</b> , to <b>11-13</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>11-13</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>M. E. Burkitt MD</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-13-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. E. Burkitt</b>		22e. ADDRESS <b>Willisuspart Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>Nov. 15, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Mem. Park</b>	
23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>Hagerstown, Wash., Maryland</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</b>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>NOV 18 1985</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-10-100

100-10-100

100-10-100

100-10-100

100-10-100

100-10-100

100-10-100

100-10-100

100-10-100

100-10-100

100-10-100

337075

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25MDHMH - 17  
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE BODY. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT (FORM 1) AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR							
Joseph F. Connolly						XX 10-30 19 85						M							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR					
Male		White		9-15-1929		56 YRS.						10-30 19 85		11:30 a. M.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Illinois				U.S.A.								Washington County, MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown				1210 W. Washington Street				Laborer											
13a. STATE												13b. CITY OR TOWN		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland												Washington		Hagerstown		YES <input type="checkbox"/> NO <input type="checkbox"/>		21740 1210 W. Washington St.	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME													
FIRST MIDDLE LAST						FIRST MIDDLE LAST													
Unknown						Unknown													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS							
Yes						WW II						344-26-2547 Doug Mullendore Washington County Sheriff's Dept.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease and Cirrhosis of Liver																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																			
(b)																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
				HOUR A.M. MONTH DAY YEAR															
				P.M. 19															
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION											
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED											
Margarita A. Korell, M.D.				M.D. Assistant				MEDICAL EXAMINER				10-31-85							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
Margarita A. Korell, M.D.				111 Penn St., Balto., Md.				21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
Burial				11-22-85				Rocky Gap Vets. Cem.				Flintstone Alleghany Wash.							
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Gerald N. Minnich				305 N. Potomac St.								John A. Miller							
Hagerstown, Maryland																			

BP

63014



63014 101103 802

3240115

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17  
(VR A15 ME (5))  
15M/7/77

FOR  
1- STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Delores		Carroll		CONWAY				11-13-85		11		13		85		9:30 M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Female	White	Mar. 16, 1903		82 YRS.						11/13/85		11		13		85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Lewistown, Pa.		U. S. A.		WIDOWED		X		Washington									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Hagerstown		Washington County Hospital		Housewife		Own Home											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS		13e. STREET ADDRESS									
Maryland		Washington		Boonsboro		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rfd. 3 Box 170								21713	
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST					
Samuel		S		Bubb		Elizabeth		M.		Gilbert							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		579-09-3288		Wm. H. Conway, Jr.		Rfd. 3 Box 170										Boonsboro, Md. 21713	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
888		Cerebrovascular accident		436													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		Atherosclerotic cardiovascular disease		437											
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		Fall at nursing home / Diabetes mellitus / morbid obesity															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		HOUR A.M. MONTH DAY YEAR															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion									
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
John H. Bast, Jr.		Boonsboro, Md. 21713															
23a. BURIAL, CREMATION, REMOVAL (SP)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
Burial		11-16-85		Cedar Hill Cemetery		Suitland, Prince Geo. Co., Md.											
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
John H. Bast, Jr.		Boonsboro, Md. 21713				11-18-85		J. H. Bast									





324029

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <sup>FIRST</sup> Margaret <sup>MIDDLE</sup> Virginia <sup>LAST</sup> CRUNKLETON <i>Crunkleton, Margaret</i>			2a. DATE OF DEATH MONTH DAY YEAR November 9, 1985		2b. HOUR M			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR June 3, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13e. STREET ADDRESS / ZIP CODE Franklin Center 21740		
14. FATHER'S NAME <sup>FIRST</sup> Albert <sup>MIDDLE</sup> S. <sup>LAST</sup> Bloom				15. MOTHER'S MAIDEN NAME <sup>FIRST</sup> Lula <sup>MIDDLE</sup> M. <sup>LAST</sup> Sites				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-09-0734-D		17. INFORMANT ADDRESS Mr. Robert L. Stouffer, Hagerstown, Md.				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarct</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	---

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>W W Lee MD</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Nov. 13, 1985		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Washington, Maryland	
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740				25a. DATE REC'D. BY REGISTRAR 25b. REG. NO. <i>1111111111</i> NOV 18 1985			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and approved in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.



312038

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ALena May CUBBAGE			2a. DATE OF DEATH MONTH DAY YEAR Nov 1, 1985		2b. HOUR 5:55 AM			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Feb. 18, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.		
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Avalon Manor		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Hungate			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Snyder					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-09-4306		17. INFORMANT ADDRESS Mrs. Josephine Guessford, Hagerstown, Md.				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic heart disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b)


DUE TO, OR AS A CONSEQUENCE OF

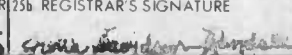
(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Chronic Obstructive Pulmonary Disease

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>December</u> , 19 <u>59</u> , to <u>October</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>October 31</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body, and death.							
22b. SIGNATURE 				DEGREE		22c. DATE SIGNED 11/1/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard N. Weeks, M.D.				22e. ADDRESS 580 Northern Avenue Hagerstown, Md. 21740			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Nov. 4, 1985		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740				25a. DATE REC'D. BY REGISTRAR NOV 06 1985		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

315038

20% COTTON FIBER

WELFAM DOWN



331022

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Bertha Mae DAVIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 17, 1985</b>		2b. HOUR <b>9:30</b> M
1. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 27, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Peter Leshner Martin</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ada Mae Strite</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-16-0321</b>		17. INFORMANT ADDRESS <b>Mary Jean Younker (item 13 above)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC FAILURE</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <b>BILIARY CIRRHOSIS</b>					<b>10 YEARS</b>
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>no</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11-17</b> , 19 <b>85</b> , to <b>11-17</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>11-17</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11.18.85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>OTTO ROZA MD</b>		22e. ADDRESS <b>100 LONGMEADOW DRIVE HAGERSTOWN MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 20, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Memorial Park</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Williamsport Washington Maryland</b>		25a. DATE RECEIVED BY REGISTRAR <b>NOV 25 1985</b>			
24. FUNERAL DIRECTOR NAME <b>Major M. Osborne Williamsport, MD 21795</b>		ADDRESS		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the health officer.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

330156



338145

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 2 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. SERVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Anna Louise Deeds		11 24 1985		2 40 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	7. IF UNDER 24 HRS.
female	white	Sept. 9, 1922	63 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	8. NEVER MARRIED	8. WIDOWED	8. DIVORCED
Pennsylvania	USA				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown	Washington County Hospital	traffic manager		lamp co.	
13a. STATE	13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
Pennsylvania	Westmoreland	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	453 Cedar Avenue 99999		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
Frederick George Butker	Mabel Edith Jones				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
No	181-12-4968	John S. Koenig			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:					minutes
IMMEDIATE CAUSE (a) <u>Cardiac arrest (427)</u>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
(b) <u>Myocardial infarction (410)</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
Obesity					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Allen W. Dittus		M.D. Dept. Assist.		11/24/85	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Allen W. Dittus M.D.		1610 Oak Hill Ave Hagerstown MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
burial	Nov. 27, 1985	Westmoreland Co. Mem. Pk.	Westmoreland Co., Pa.		
24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
MINNICH FUNERAL HOME	415 E. Wilson Blvd., Hagerstown, Md. 21740		DEC 02 1985 John Swiden		



UNCLASSIFIED

20% COTTON YARN

Handwritten text

Handwritten text

Handwritten text

Handwritten text

Handwritten text

Handwritten text

Handwritten text

319082

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Ralph W. Dick</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>09 25 1985</b>		2b. HOUR <b>4 PM</b>								
3. SEX <b>Male</b>		4. RACE <b>Can.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 25 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.			
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Big Pool, Md.</b>		9b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington Co.</b> MD.							
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md</b>						13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Boonsboro</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Rfd. 4 Box 124B 21713</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Cletus B. Dick</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edith V. Hetzer</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-10-3415A</b>		17. INFORMANT ADDRESS <b>Mrs. Mary E. Dick, Rfd. 4 Box 124A Boonsboro, Md. 21713</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Abdul Wahed</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/10/85</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ABDUL WAHEED MD</b>						22e. ADDRESS <b>1610 Oak Hill NE HAG. MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11-12-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Park Head Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clearspring, Wash. Co., Md.</b>					
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. Boonsboro, Md. 21713</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John H. Bast, Jr.</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Mr. J. Edgar Hoover  
U. S. A.  
Washington, D. C.  
Box 1548  
11-10-52  
Mr. J. Edgar Hoover  
U. S. A.  
Washington, D. C.  
Box 1548  
11-10-52

Mr. J. Edgar Hoover  
U. S. A.  
Washington, D. C.  
Box 1548  
11-10-52  
Mr. J. Edgar Hoover  
U. S. A.  
Washington, D. C.  
Box 1548  
11-10-52

4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 may be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

322169

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>WAYNE E. DRAPER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 - 11 - 85</b>		2b. HOUR <b>7 40 P.M.</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 17, 1937</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>48</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Hagerstown, Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.		
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Truck Mfg. Co.</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Fairplay</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>Rfd. 1 Box 39A 21733</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Hawbaker Draper</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Harriet Catherine Showman</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. <b>220-34-0332</b>	17. INFORMANT ADDRESS <b>Rfd. 1 Box 39A Mrs. Olive C. Draper, Fairplay, Md. 21733</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>lymphoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>A. W. Good</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/11/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ABDUL WAHEED MD</b>		22e. ADDRESS <b>1610 - OAK HILL NE HAG. MD 21740</b>			
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>	23b. DATE <b>11-14-85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Boonsboro, Wash. Co., Md.</b>		
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. Boonsboro, Md. 21713</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1985</b>	25b. REGISTRAR'S SIGNATURE	

BP

© JCR

221

1991. 11. 10. 1002

3

.IM .INCHES

• 4 •

notified.

[illegible]

100

00-238 COURT

Washington, D.C.

100

422C

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

192 205 1 . 016

550-37-235

JAN 17 - 62

of the ... ..

325090

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carder papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 is not marked, the medical examiner must be notified at once.

DHMH - 16 50M 1/76  
(VR A 15 (4))STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MILDRED MARIE DUFFEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 12, 1985</b>		2b. HOUR 5:45 M		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 30, 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS. MONTHS DAYS HRS. MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Co Owner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Washington</b> 13c. CITY OR TOWN <b>Clear Spring</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Route # 3 Box 68</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Andrew S. Shupp</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bertha Mae Staley</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>170-32-3258</b>		17. INFORMANT ADDRESS <b>Route # 3 Box 68 Eugene A. Duffey Sr. Clear Spring, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CYSTADENO CARCINOMA OF OVARY WITH WIDESPREAD</b> DUE TO, OR AS A CONSEQUENCE OF <b>INTRA-ABDOMINAL METASTASIS</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2-3 YEARS</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) ( <del>XXXXXX</del> ) attended the deceased from <b>SEPT. 24</b> , 19 <b>85</b> , to <b>Nov. 12</b> , 19 <b>85</b> , that (I) ( <del>X</del> ) lost saw the deceased alive on <b>Nov. 5</b> , 19 <b>85</b> , and that in (my) ( <del>X</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>XX</del> ) (did) ( <del>XXX</del> ) view the body after death.							
22b. SIGNATURE <i>Edward W. Ditto, III</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Nov. 12, 1985</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD W. DITTO, III, M.D.</b>				22e. ADDRESS <b>217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-15-85</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Lawn Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Washington, Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Thompson Funeral Home, Inc. Clear Spring Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 18 1985</b>		25b. REGISTRAR'S SIGNATURE <i>Lelia Davidson-Randall</i>	

BP

FILED MAR 15 1952  
JULY 15 1952  
NOVEMBER 15 1952

WASHINGTON

RECEIVED MAR 15 1952  
MAR 15 1952  
MAR 15 1952

RECEIVED MAR 15 1952  
MAR 15 1952  
MAR 15 1952

RECEIVED MAR 15 1952  
MAR 15 1952  
MAR 15 1952

RECEIVED MAR 15 1952  
MAR 15 1952  
MAR 15 1952

RECEIVED MAR 15 1952  
MAR 15 1952  
MAR 15 1952

RECEIVED MAR 15 1952  
MAR 15 1952  
MAR 15 1952



338047

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME FIRST MIDDLE LAST <b>Isabel Elizabeth Easterday</b>		MONTH DAY YEAR <b>11-26-85</b>		10:25PM	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6-6-1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Boonsboro</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Reeders Memorial Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Boonsboro</b>	
13a. STATE <b>Maryland</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Route # 2 Box 126</b>		<b>21713</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>David C. Horn</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma E. Staley</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-46-5001</b>		17. INFORMANT ADDRESS <b>Route # 2 Box 126 Boonsboro, Md. 21711</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic cancer to liver</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>primary unknown</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>3 months</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6</b> , 19 <b>85</b> , to <b>11/16</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>11/26</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>P.L. KUGLER</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/27/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P.L. KUGLER, M.D.</b>		22e. ADDRESS <b>P.O. BOX 246 KEEPYVILLE, MD. 21752</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-29-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery Hagerstown, Washington, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>A.K. Coffman Funeral Home, Inc.</b>		ADDRESS <b>Hagerstown, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 2 1985</b>	
				25b. REGISTRAR'S SIGNATURE	

338017



1

325132

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Julia Jacinta Fernandez</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 10 1985</b>		2b. HOUR <b>220 AM</b>	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 9, 1909</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Santiago, Chile</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.				
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE <b>806 Potomac Towers 21740</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Manuel y Villavicencio</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jovita Y. Villavicencis Roche</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Julia Cardenas, Hagerstown, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fibrous Mesothelioma of the lungs &amp; pleura with widespread metastases</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypoglycemia accompanying tumor</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>16 years</b> <b>3 months</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (a) this hospital attended the deceased from <b>11/9</b> 19 <b>85</b> , to <b>11/11</b> 19 <b>85</b> , that (b) (we) lost saw the deceased <b>die</b> on <b>11/9</b> 19 <b>85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (c) we (did/did not) view the body after death.						
22b. SIGNATURE <b>Robert Brull</b>		22c. DATE SIGNED <b>11/10/85</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert Brull MD</b>		
22e. ADDRESS <b>1459 Potomac Ave. Hagerstown</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>cremation</b>				
23b. DATE <b>Nov. 11, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Smithsburg, Wash., Maryland</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740</b>						

2  
35  
211  
9  
9  
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

322044

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST <b>Hazel</b> MIDDLE <b>Elizabeth</b> LAST <b>FORBES</b> <b>HAZEL FORBES</b>		2a. DATE OF DEATH MONTH <b>11</b> DAY <b>4</b> YEAR <b>85</b> 2b. HOUR <b>3:45</b> P.M.	
3. SEX <b>Female</b>	4. RACE <b>CAUCASION</b>	5. DATE OF BIRTH MONTH <b>10</b> DAY <b>27</b> YEAR <b>07</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.		
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>N.C.</b>		13b. COUNTY <b>Rowan</b>	13c. CITY OR TOWN <b>Salisbury</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>128 N. Merritt Ave. 28144</b>
14. FATHER'S NAME FIRST <b>Ernest</b> MIDDLE <b>Sloop</b> LAST <b>Sloan</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Susan</b> MIDDLE <b>J.</b> LAST <b>Bostian</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>239-46-8591</b>		17. INFORMANT ADDRESS <b>Mrs. S. Patricia Gardenhour Smithsburg, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/5/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ABDUL WAHEED, MD</b>		22e. ADDRESS <b>1610 - OAK HILL AVE, HAG, MD 21740</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Nov. 7, 1985</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chestnut Hill Cemetery</b>	23d. LOCATION CITY OR TOWN <b>Salisbury</b> COUNTY <b>Rowan</b> STATE <b>N.C.</b>		
24. FUNERAL DIRECTOR NAME <b>Dennis L. Davis</b> ADDRESS <b>Davis Funeral Home Smithsburg, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV. 13 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

33304



322004

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Helen D. Goodwin</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-4-85</b>			2b. HOUR <b>12 noon</b>			
3. SEX <b>Female</b>		4. RACE <b>Cau.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5-16-1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>831 Rolling Road</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fairchild</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>831 Rolling Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Price Davis</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Della Carr</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-10-1427</b>		17. INFORMANT ADDRESS <b>Della D. Berg same as 13</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant lymphoma, Non Hodgkins</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Renal failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 1/2 yrs</b> <b>1 week.</b>
--	--	---

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>Aug</b> 19 <b>73</b> to <b>Nov 4</b> 19 <b>85</b> , that (1) (we) lost saw the deceased alive on <b>Nov 30</b> 19 <b>85</b> , and that in (m) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>Richard E. Smith, M.D.</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>		22c. DATE SIGNED <b>11/4/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard E. Smith, M.D.</b>				22e. ADDRESS <b>1708 Oak Hill Ave, Hagerstown, Md</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-6-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery Hagerstown Wash. Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Gerald N. Minnich Hagerstown, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 12 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low required for the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and filed with the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.

BP.





337013

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>EARL C HART PENCE</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>NOV 24, 1985</b>		2b. HOUR <b>4:30 PM</b>
3. SEX <b>MALE</b>	4. RACE <b>CAUC.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>August 3, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>electrician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>private indust.</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Clear Spring</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>William J. Hartpence</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edith Weignan</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>150-01-5710A</b>		17. INFORMANT ADDRESS <b>William Hartpence, Clear Spring, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SUBARACHNOID HEMORRHAGE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPERTENSION</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Edward Byrd M.D.</b>		DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>		22c. DATE SIGNED <b>24 Nov. 85</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD BYRD, M.D.</b>		22e. ADDRESS <b>1198 KENLY AVE. HAGERSTOWN</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>	23b. DATE <b>Nov. 26, 1985</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bound Brook Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bound Brook, N.J.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</b>		25a. DATE RECEIVED BY REGISTRAR <b>NOV 29 1985</b>		
25b. REGISTRAR'S SIGNATURE				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

337013



NOT WITHHOLD

RECEIVED

323095

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			3. SEX			4. RACE			5. DATE OF BIRTH		
ARTHUR K HAWSE			Male			White			Oct 15, 1906		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
West Virginia			U.S.A.						WASHINGTON MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
HAGERSTOWN			AVALON MANOR			Farmer			Farming		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
W. Va.			Hampshire			Shanks			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
Daniel			Mary			yes			232-26-0224		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		
Mrs. Beatrice Pownell Romney, W. Va.			PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory Failure			None			----		
			DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia								
			DUE TO, OR AS A CONSEQUENCE OF (c) Obstructive Pulmonary Disease								
			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Rt sided paralysis; Aphasia								
			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
			21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
						HOUR A.M. MONTH DAY YEAR					
						P.M. none 19					
			21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION		
			WHERE AT WORK <input type="checkbox"/> NOT WHERE AT WORK <input type="checkbox"/>			none			STREET CITY OR TOWN COUNTY STATE		
			22a. I certify that (I) (this hospital) attended the deceased from			22b. SIGNATURE			22c. DATE SIGNED		
			Oct 24 1985, to Nov 10 1985, that (I) (we) last saw the deceased alive on 11/10/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.			V.W. Lesh M.D.			11-11-85		
			22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
			4 William W. Lesh M.D.			411 Division Ave Hagerstown, Md.					
			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
			Burial			11/13/85			Mt. Dale Cemetery		
									23d. LOCATION		
									CITY OR TOWN COUNTY STATE		
									Shanks Hampshire W. Va.		
			24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
			James R. Cyles			Augusta, W. Va.					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card on back of page 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 gives any injury, or other traumatic event, the medical examiner must be notified at once.



379108

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Jack Sherley Hennesy</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 30 85</b>			2b. HOUR MIN. <b>12<sup>02</sup> AM</b>			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 7, 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67 YRS</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington MD.</b>			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing Fixture</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>115 Allen Avenue 21740</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry J. Hennesy</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth M. Miller</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>219-07-0980</b>		17. INFORMANT ADDRESS <b>Mrs. Katharine Hennesy, Hagerstown, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/30/85</b> 19 <b>85</b> , to <b>11/30/85</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>11/30/85</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Lucille A. [Signature]</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/30/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>			23b. DATE <b>Dec. 3, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Williamsport. Wash., Maryland</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>MINNICH FUNERAL HOME 415 E. [Address] Hagerstown, MD.</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 3 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP \_\_\_\_\_

(A)



20X COLLECTION



326096

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Paul Vincent Irby</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11 12 85</b>		2b. HOUR <b>4:05 PM</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 13 1916</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE <b>Maryland</b>		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>truck driver</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. COUNTY <b>Washington</b>		13b. CITY OR TOWN <b>Hagerstown</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Elijah Irby</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lenora Mose</b>		13d. STREET ADDRESS / ZIP CODE <b>2457 Virginia Ave. 21740</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W. II 214-09-4044</b>		17. INFORMANT ADDRESS <b>Irene Irby, Hagerstown, Md.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>instant</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>hypertensive cardiovascular disease</b>		
DUE TO, OR AS A CONSEQUENCE OF (c) <b>year</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)		

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 12, 1985</b> to <b>Nov 14, 1985</b> , that (I) (we) last saw the deceased alive on <b>Nov 14, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Edson B. Moody</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/14/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Edson B. Moody</b>		22e. ADDRESS <b>AT #3 Box 163 Hagerstown, Md</b>					

23a. BURIAL, CREMATION, REMOVAL SPECIFY <b>Burial</b>		23b. DATE <b>Nov. 15, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>MINNICH FUNERAL HOME</b> <b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 20 1985</b>			
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 must be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

320036



NOTA

MALEFICIA

NOTA NOTION % 22

*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

337145

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Clayton Elias JACOBS Jr.			2a. DATE OF DEATH MONTH DAY YEAR Nov. 22, 1985			2b. HOUR 10:58 AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 4, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 64		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer		12b. KIND OF BUSINESS OR INDUSTRY Tannery Co.		
13a. STATE Md.			13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 204 N. Cannon Ave. 21740	
14. FATHER'S NAME FIRST Clayton MIDDLE E. LAST Jacobs Sr.			15. MOTHER'S MAIDEN NAME FIRST Ida MIDDLE LAST Snook							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. JWW 11 219-05-2041		17. INFORMANT ADDRESS Mrs. Juanita J. Jacobs Hagerstown, Md.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), (c), (d), (e), (f), (g), (h), (i), (j), (k), (l), (m), (n), (o), (p), (q), (r), (s), (t), (u), (v), (w), (x), (y), (z). PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), (b), (c), (d), (e), (f), (g), (h), (i), (j), (k), (l), (m), (n), (o), (p), (q), (r), (s), (t), (u), (v), (w), (x), (y), (z). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 19a. DATE OF OPERATION 11-22-85 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II) 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 22a. I certify that (I) (this hospital) attended the deceased from 11-22-85 to 11-22-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. 22b. SIGNATURE E. R. Ford 124624 DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22c. PHYSICIAN'S NAME (TYPE OR PRINT) E. R. Ford 124624 22d. ADDRESS 388 Bond St. Hagerstown, Md. 22e. DATE SIGNED 11-22-85 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE Nov. 25, 1985 23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery 23d. LOCATION Smithsburg, Wash. D.C. STATE 24. FUNERAL DIRECTOR NAME Davis Funeral Home ADDRESS Smithsburg, Md. 25a. DATE REC'D. BY REGISTRAR NOV 27 1985 25b. REGISTRAR'S SIGNATURE										

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to cause an autopsy.

BP



*Handwritten text, possibly a signature or date, in the center of the page.*

316005

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Helen J. KAERCHER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 2, 1985</b>			2b. HOUR <b>5 P M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 13, 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Black Truck</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Omfry Shusko</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>194-12-6426</b>		17. INFORMANT ADDRESS <b>Robert C. Kaercher Same as 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESP Arrest</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastatic endometrial</b>							
(c) <b>CARCINOMA -</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>C. Hooster MD</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/2/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS <b>1825 Howell Rd Hagerstown MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-6-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown Wash. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Gerald N. Minnich Hagerstown, Maryland</b>				25a. DATE REC'D BY REGISTRAR <b>NOV 07 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

Report of the

Director

of

the

Department of Justice

Washington, D.C.

January 1, 1964



312032

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLARA Helen KARN			2a. DATE OF DEATH: MONTH DAY YEAR November 1, 1985			2b. HOUR M			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR November 16, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 266 South Potomac Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 266 South Potomac Street 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Jonas Lee Hockman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Amada Duke					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-18-8796		17. INFORMANT ADDRESS Mr. Donald W. Karn, Hagerstown, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF 1b DUE TO, OR AS A CONSEQUENCE OF 1c								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last: } <i>myocardial infarction coronary artery dis Arteriosclerotic CVD</i>								<i>1 day</i> <i>years</i> <i>years</i>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Chronic dist. Colon Dis; Prost shoulder fracture</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINERS)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, PART 1, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>10 Feb 1968</i> to <i>date</i> that (I) (we) last saw the deceased alive on <i>31 Oct 1985</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) and not saw the body after death.									
22b. SIGNATURE <i>Richard T. Binford</i>		22c. PHYSICIAN'S NAME (TYPE OR PRINT) Binford		22d. ADDRESS Hagerstown, Md		22e. DATE SIGNED 1 Nov 85		22f. ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Nov. 4, 1985		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 East Wilson Blvd., Hagerstown, Maryland 21740				25a. DECEASED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>MIN 06 1985</i>					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 4.





1st  
 2nd  
 3rd  
 4th  
 5th  
 6th  
 7th  
 8th  
 9th  
 10th  
 11th  
 12th  
 13th  
 14th  
 15th  
 16th  
 17th  
 18th  
 19th  
 20th  
 21st  
 22nd  
 23rd  
 24th  
 25th  
 26th  
 27th  
 28th  
 29th  
 30th  
 31st  
 32nd  
 33rd  
 34th  
 35th  
 36th  
 37th  
 38th  
 39th  
 40th  
 41st  
 42nd  
 43rd  
 44th  
 45th  
 46th  
 47th  
 48th  
 49th  
 50th  
 51st  
 52nd  
 53rd  
 54th  
 55th  
 56th  
 57th  
 58th  
 59th  
 60th  
 61st  
 62nd  
 63rd  
 64th  
 65th  
 66th  
 67th  
 68th  
 69th  
 70th  
 71st  
 72nd  
 73rd  
 74th  
 75th  
 76th  
 77th  
 78th  
 79th  
 80th  
 81st  
 82nd  
 83rd  
 84th  
 85th  
 86th  
 87th  
 88th  
 89th  
 90th  
 91st  
 92nd  
 93rd  
 94th  
 95th  
 96th  
 97th  
 98th  
 99th  
 100th

1st  
 2nd  
 3rd  
 4th  
 5th  
 6th  
 7th  
 8th  
 9th  
 10th  
 11th  
 12th  
 13th  
 14th  
 15th  
 16th  
 17th  
 18th  
 19th  
 20th  
 21st  
 22nd  
 23rd  
 24th  
 25th  
 26th  
 27th  
 28th  
 29th  
 30th  
 31st  
 32nd  
 33rd  
 34th  
 35th  
 36th  
 37th  
 38th  
 39th  
 40th  
 41st  
 42nd  
 43rd  
 44th  
 45th  
 46th  
 47th  
 48th  
 49th  
 50th  
 51st  
 52nd  
 53rd  
 54th  
 55th  
 56th  
 57th  
 58th  
 59th  
 60th  
 61st  
 62nd  
 63rd  
 64th  
 65th  
 66th  
 67th  
 68th  
 69th  
 70th  
 71st  
 72nd  
 73rd  
 74th  
 75th  
 76th  
 77th  
 78th  
 79th  
 80th  
 81st  
 82nd  
 83rd  
 84th  
 85th  
 86th  
 87th  
 88th  
 89th  
 90th  
 91st  
 92nd  
 93rd  
 94th  
 95th  
 96th  
 97th  
 98th  
 99th  
 100th

337015

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT) <b>CHARLES J. KEEDY</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11-24-85</b>		2b. HOUR <b>5<sup>10</sup> AM</b>	
3 SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 14 02</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON</b> MD.	
10. CITY OR TOWN OF DEATH <b>HALESTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CLEARVIEW NURSING HOME</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RAILROAD</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>WASH.</b>		13c. CITY OR TOWN <b>HALESTOWN</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES N KEEDY</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EMMA Fleet</b>		17 INFORMANT ADDRESS <b>Mrs. Ella M. Keedy, Williamsport, Md.</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>705-10-4602</b>		17. INFORMANT ADDRESS <b>Mrs. Ella M. Keedy, Williamsport, Md.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <b>Metastasis to liver, chronic obstructive pulmonary disease, chronic kidney disease</b>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <b>10/16/85</b> to <b>11/19/85</b> , that (I) (we) last saw the deceased alive on <b>11/19/85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.			
22b. SIGNATURE <b>Edward Sherry</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>	23b. DATE <b>Nov. 26, 1985</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Maryland</b>
24 FUNERAL DIRECTOR NAME ADDRESS <b>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</b>		25a. DATE REC'D BY REGISTRAR <b>NOV 29 1985</b>	25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified without delay.

MEDICAL CERTIFICATION

BP

10752

20% COTTON FIBER

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1- STATE  
REGISTRAR

REG. NO.

319113

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Marie SLAYMAN KERNS		November 2, 1985		5:20 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. IF UNDER 1 YEAR	
Female	White	Feb. 20, 1904	81	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Washington County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY
Williamsport	Homewood Retirement Center		Food Service		Aircraft Co.
13a. STATE		13b. CITY OR TOWN	13c. STREET ADDRESS / ZIP CODE		
Maryland	Washington	Clear Spring	17222 17 North Mill Street		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Abraham Lincoln Slayman		Darcus Dickens			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		218-30-9159		2104 Reuter Road Timonium, Md. 21093	
18. CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>INTRACRANIAL EDEMA</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>MASSIVE INTRACRANIAL HEMORRHAGE</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>0</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
(IF EITHER, NOTIFY MEDICAL EXAMINER)		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/7/85</u> 19 <u>85</u> to <u>10/10</u> 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>10/10</u> 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, (I) (did) not visit the body after death.)					
22b. SIGNATURE		22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS	
<u>[Signature]</u>		STEPHEN E. METZNER, MD		1855 Hawes Rd Hagerstown Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		11-5-85		St. Paul's Cemetery Clear Spring, Washington, Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Thompson Funeral Home, Inc. Clear Spring		Nov 08 1985		<u>[Signature]</u>	

111113

STAYMAN

Female

White

Yrs. 20, 1900

52

Married

U.S.A.

Washington, D.C.

Williamport

Food Service Center

Food Service Center

Washington Clear Spring

Clear Spring

Clear Spring

Lincoln

Lincoln

Lincoln

Lincoln

1918-20-21

1918-20-21

1918-20-21

1918-20-21

1918-20-21

1918-20-21

Married

1918-21

Washington Clear Spring

Washington Clear Spring

337034

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>KATIE NMN KLINK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 23, 1985</b>			2b. HOUR <b>3:30 P M</b>				
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 15, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Yugoslavia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON</b> MD.				
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>AYALON MANOR</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>536 Antietam Drive 21740</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Milo Sakic</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maria</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-54-0959</b>		17. INFORMANT ADDRESS <b>Mr. Michael Klick, Hagerstown, Maryland</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Multiple System Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis, generalized,</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>23 June</b> , 19 <b>77</b> , to <b>23 Nov.</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>20 Nov.</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>W. N. Fender</b> MD				DEGREE		22c. DATE SIGNED <b>24 Nov. 85</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. N. Fender</b>				22e. ADDRESS <b>138 E. Antietam St. Hagerstown Md 21740</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>Nov. 27, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Maryland</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>MINNICH FUNERAL HOME 415 East Wilson Blvd., Hagerstown, Maryland 21740</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1985</b>						
				25b. REGISTRAR'S SIGNATURE <b>John Fender</b>						

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the attending physician. The low requires that the death certificate be executed with the attending physician. The low requires that the death certificate be executed with the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner will be notified of same.

180512

4014

18

180512 4014



322084

FOR  
STATE  
REGISTRAR **RAY RICHARD KLINE**

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Ray Richard Kline</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11/5/85</b>		2b. HOUR <b>10:25A</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 5, 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS	IF ELDERLY YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Western Maryland Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Track Man</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Clear Spring</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Hamilton Kline</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marie Mann</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-09-9087</b>		17. INFORMANT ADDRESS <b>Charles L. Kline 245 N. Locust Street Hagerstown, Md. 21740</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>day</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>Arteriosclerosis</b>					
19a. DATE OF OPERATION <b>9/13/85</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>gangrene left leg</b>		20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10/14/85</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (CITY OR TOWN) COUNTY STATE <b>11/5/85</b>	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death. <b>11/5/85</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/5/85</b> and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated.					
22b. SIGNATURE <b>Florencia P. Palomo</b>		DEGREE		22c. DATE SIGNED <b>11/5/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Florencia P. Palomo</b>		22e. ADDRESS <b>1500 Penn A, Hagerstown MD 21740</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-8-85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Shanktown Cemetery</b>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>Big Pool, Washington, Md.</b>
24. FUNERAL DIRECTOR NAME <b>Thompson Funeral Home, Inc. Clear Spring</b>		ADDRESS <b>Md.</b>		25a. DATE RECD. BY REGISTRAR <b>11/5/85</b>	
				25b. REGISTRAR'S SIGNATURE <b>Ray Richard Kline</b>	

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

ON COTTON FIBRE

WHEAT FLOUR

100000

WY. RICHARD KLINE

Maryland U.S.A.

March 1, 1900

Kline

30 N. Main Street  
Baltimore  
Maryland

John Hamilton Kline

287-00-0007 Charles A. Kline  
202 N. Cooper Street  
Baltimore, Md. 2124



Thompson Metal Works, Inc. Clean Springs  
No. 1  
11-8-02  
Baltimore, Maryland

338051

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Angela Christina LANGENSTEIN			2a. DATE OF DEATH MONTH DAY YEAR November 26, 1985		2b. HOUR M
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR April 18, 1935		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Route 3, Box 168		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Stanley A. Kriticopolou		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Antoinette			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 101-26-2376		17. INFORMANT ADDRESS Gerald Langenstein, Hagerstown, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years
---	--	---

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/84</u> , 19 <u>84</u> , to <u>11/26</u> , 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>11/27/85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Frederic H. Kass</u>		DEGREE MD		22c. DATE SIGNED 11/27/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederic H. Kass, MD		22e. ADDRESS 1825 Howell Rd Hagerstown, MD. 21740			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE Nov. 30, 1985	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740		25a. DATE REC'D. BY REGISTRAR DEC 2 1985	
		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 4 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and an autopsy will be required.

338051

1



THE UNIVERSITY OF CHICAGO PRESS

322064

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>RUSSELL H. LINTON</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11 07 85</b>				2b. HOUR <b>803 PM</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 02 03</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Colton Villa Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Foreman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Elec manufacturing</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Frederick</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>816 Trail Ave., 21701</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel I. Linton</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Stone</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>None</b>		17. INFORMANT <b>Jack T. Linton,</b>		ADDRESS <b>814 Trail Ave.,</b>		CITY OR TOWN, STATE, ZIP CODE <b>Frederick, Md. 21701</b>			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Abdul W. L. H. W. W. W.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11/8/85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ABDUL W. L. H. W. W. W.</b>				22e. ADDRESS <b>1610 Oak Hill Avenue Hagerstown, MD 21740</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov 9, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frederick, Frederick, Md.</b>					
24. FUNERAL DIRECTOR <b>Smith, Keeney and Basford Funeral Home</b>						25a. DATE REC'D. BY REGISTRAR <b>11/13/85</b>					
25b. REGISTRAR'S SIGNATURE <b>John L. Linton</b>											

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2  
[Faint, illegible text]

[Faint, illegible text]

[Faint, illegible text]

[Faint, illegible text]

[Faint, illegible text]

[Faint, illegible text]

[Faint, illegible text]

[Faint, illegible text]

[Faint, illegible text]

[Faint, illegible text]

[Faint, illegible text]

[Faint, illegible text]

[Faint, illegible text]

[Faint, illegible text]

[Faint, illegible text]





330005

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

Margaret

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Margaret</u> <u>Lowman</u>		2a. DATE OF DEATH MONTH DAY YEAR <u>11</u> - <u>12</u> - <u>85</u>		2b. HOUR <u>3:48</u> PM	
3. SEX <u>Female</u>		4. RACE <u>Black</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>03</u> - <u>07</u> - <u>1925</u>	
6. AGE (IN YEARS LAST BIRTHDAY) <u>60</u> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		8. BALTIMORE CITY OR COUNTY OF DEATH <u>Washington County</u> MD.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pennsylvania</u>		9b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
11. CITY OR TOWN OF DEATH <u>Hagerstown</u>		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington County Hospital</u>		13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>	
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 14a. STATE <u>Pennsylvania</u>		14b. COUNTY <u>Franklin</u>		14c. CITY OR TOWN <u>Waynesboro</u>	
15. FATHER'S NAME FIRST MIDDLE LAST <u>George</u> <u>Mosten</u>		16. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Sarah</u> <u>C.</u> <u>Johnson</u>		17. STREET ADDRESS / ZIP CODE <u>114 Eden Avenue</u> <u>99999</u>	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		18b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>201-18-3293</u>		19. INFORMANT ADDRESS <u>Phillip Lowman 114 Eden Ave., Waynesboro, PA 17268</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Renal failure

DUE TO, OR AS A CONSEQUENCE OF

(b) Diabetes mellitus

DUE TO, OR AS A CONSEQUENCE OF

(c) Atherosclerotic cardiovascular disease

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

emphysema

9a. DATE OF OPERATION		19a. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>Nov 12</u> , 19 <u>85</u> , to <u>Nov 12</u> , 19 <u>85</u> , that (we) last saw the deceased alive on <u>Nov 12</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (or last seen) (did not view the body after death).							
22b. SIGNATURE <u>George Newman II M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/13/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>George Newman II</u>				22e. ADDRESS <u>1825 Howell Rd., Hagerstown, Md. 21740</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>11/16/1985</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Waynesboro Franklin PA</u>	
24. FUNERAL DIRECTOR NAME ADDRESS <u>David L. Cox</u> <u>50 S. Broad St. Waynesboro, Penna.</u>				25a. DATE REC'D. BY REGISTRAR <u>Nov 19 1985</u>		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.





Handwritten notes and markings at the top right of the page, including what appears to be a signature or initials.

Handwritten notes and markings in the middle right section of the page.

Handwritten notes and markings in the lower middle right section of the page.

Handwritten notes and markings at the bottom right of the page.

Washington County

Hamsville

Johnston

Johnston

Johnston

Johnston

Phillip Lowman in Room 401, Johnston, N.C.

Johnston, N.C.

Johnston, N.C.

Johnston, N.C.

Johnston, N.C.

Johnston, N.C.

Johnston, N.C.

Johnston, N.C.

Johnston, N.C.

Johnston, N.C.

Johnston, N.C.

Johnston, N.C.

Johnston, N.C.

337014

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Milton Harold LUSHBAUGH			2a. DATE OF DEATH MONTH DAY YEAR November 24, 1985		2b. HOUR 6:00 A.M.								
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR July 15, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.							
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 330 Vista Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) sheet metal worker			12b. KIND OF BUSINESS OR INDUSTRY aircraft				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 330 Vista Street 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Lester Lushbaugh				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Gearhart									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II		17. INFORMANT Mrs. Louise M. Lushbaugh, Hagerstown, MD.				ADDRESS			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>15 YEARS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>DIABETES MELLITUS; HYPERTENSION</u>													
19a. DATE OF OPERATION <u>NONE</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>FEBRUARY 6</u> , 19 <u>80</u> , to <u>NOVEMBER 24</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>OCTOBER 14</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>[Signature]</u>				DEGREE <u>MD</u>				22c. DATE SIGNED <u>11-25-85</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BARRY M. COHEN</u>				22e. ADDRESS <u>339 E. ANTIETAM ST</u> <u>HAGERSTOWN, MD, 21740</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Nov. 27, 1985		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland							
24. FUNERAL DIRECTOR NAME 415 East Wilson Blvd., Hagerstown, Maryland 21740				25a. DATE REC'D. BY REGISTRAR <u>NOV 29 1985</u>									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is signed, injury, or other traumatic event, the medical examiner must be notified at once.

BP

THE LIBRARY OF  
CONGRESS  
1054 DUBLIN ST. N.W.  
WASHINGTON, D.C. 20540

84

11-22-84

11-22-84

11-22-84

11-22-84

11-22-84

11-22-84

11-22-84

11-22-84

11-22-84

11-22-84

11-22-84

11-22-84

11-22-84

319090

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified.

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		M	
FIRST MIDDLE LAST		November 5, 1985			
Frances Young MACHEN					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
female	white	MONTH DAY YEAR	72	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA		Washington	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Hagerstown	1300 Hamilton Boulevard		teacher		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
Maryland	Washington	Hagerstown	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
J. Lloyd Harshman		Stella M. Young			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		219-36-3754		Howard C. Machen, Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>Probable acute myocardial infarction</i>					<i>Immediate</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic cardiovascular disease</i>					<i>10 yrs.</i>
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
				STREET CITY OR TOWN COUNTY STATE	
22. I certify that (a) (the hospital) attended the deceased from <i>Nov 7</i> , 19 <i>80</i> , to <i>Nov 5</i> , 19 <i>85</i> , that (b) (we) last saw the deceased alive on <i>Oct 9</i> , 19 <i>85</i> , and that in (c) (my) opinion death occurred on the date and hour and from the causes stated above. (d) (we) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<i>Richard E. Smith, M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		11-6-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Richard E. Smith, M. D.		1708 Oak Hill Ave., Hagerstown, Md. 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
burial		Nov. 8, 1985		Rest Haven Cemetery	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
MINNICH FUNERAL HOME		415 E. Wilson Blvd., Hagerstown, Md. 21740		25b. REGISTRAR'S SIGNATURE	
				NOV 12 1985	

BP

312030

1

13-6-1952

1708 Oak Hill Ave., Hagerstown, Md. 21760

Mr. J. Edgar Hoover, U.S. Dept. of Justice

338046

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST Frances Estelle MAIN		MONTH DAY YEAR November 23, 1985		P M 12:10	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 5, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co. MD.	
10. CITY OR TOWN OF DEATH Williamsport	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Homewood Retirement Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home
13a. STATE Md.		13b. COUNTY Fred.	13c. CITY OR TOWN Middletown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST VINCENT FLOOK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JEANETTE SMITH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-01-3957		17. INFORMANT ADDRESS Janet Young Middletown, Md. 21769	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ALZHEIMER'S DISEASE.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 85</u> , 19 <u>85</u> , to <u>Nov</u> , 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>10/16</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)					
22b. SIGNATURE <u>[Signature]</u>		22c. DATE SIGNED <u>11/25/85</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>STEPHEN E. METZEN, MD</u>	
22e. ADDRESS <u>1825 Hawley Rd Hagerstown, Md</u>		22f. DATE OF DEATH BY REGISTRAR <u>DEC 2 1985</u>		22g. REGISTRAR'S SIGNATURE	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Nov. 26, 1985</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery Middletown Fred. Md.</u>	
24. FUNERAL DIRECTOR NAME <u>Thompson Funeral Home Middletown, Md.</u>		25a. DATE OF DEATH BY REGISTRAR <u>DEC 2 1985</u>			

MEDICAL CERTIFICATION

35  
90  
35  
100  
2

9  
9

1

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then pages 1, 2, and 4 should be filed with the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

332016

Female  
White  
March 1907 80  
Washington Co.  
own home  
2170  
VIRGINIA  
210-01-3079 Janet Young 210-01-3079  
2170

1

Thompson Funeral Home 2170  
Nov. 2, 1907  
2170  
2170



322039

DIVISION OF VITAL RECORDS, 201 W. PRESIDENT STREET, BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. HAVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER (LONG FORM 34). RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESIDENT STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1- FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HERBERT LEWIS MANSPEAKER</b>										2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>Nov. 6 1985</b>		2b. HOUR MIN <b>9:40</b>	
3 SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 13, 1927</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>58</b>		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>Nov. 6 1985</b>		2d. HOUR MIN <b>9:55</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON</b>			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Plumber</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>	
13a. STATE <b>Md.</b>				13b. COUNTY <b>Wash.</b>		13c. CITY OR TOWN <b>Smithsburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt 3 Box 65</b>		21783	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Marshall Manspeaker</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>Blanche Runkles</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT ADDRESS <b>Mrs. June E. Manspeaker Smithsburg, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>#427 - CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>#414 - ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMED.</b> <b>5 YEARS</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>Edward W. Ditto</i>				TITLE (SPECIFY) <b>DEPUTY</b>				DATE SIGNED <b>Nov. 6, 1985</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>EDWARD W. DITTO, III, M.D.</b>				ADDRESS <b>217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Nov. 9, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Smithsburg, Wash, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Dennis Davis</b>				ADDRESS <b>Funeral Home Smithsburg, Md.</b>				DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE <i>Julia T. Davis</i>	

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (15))

325053

LEWIS

MANABAKER

NOV. 5 1940

WASHINGTON

NOV. 5 1940

NOV. 5 1940

NOV. 5 1940

LEWIS

NOV. 5 1940

NOV. 5 1940

LEWIS

NOV. 5 1940

NOV. 5 1940

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

322078

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Myrtle Sarah Marshall</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 1 85</b>		2b. HOUR <b>4:15P M</b>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>August 1, 1882</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>103</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington MD</b>	
10. CITY OR TOWN OF DEATH <b>Boonsboro</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Reeders Memorial Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Boonsboro</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>141 S. Main Street 21713</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thadeus T. Forney</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ellen Moser</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-01-6162</b>		17. INFORMANT ADDRESS <b>Mrs. Arthur Flanigan 11629 Haugh's Church Keymar, Md. 21757</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardio-respiratory arrest Secondary to CVA**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>[Signature]</i> MD	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-2-85</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Boonsboro, Maryland</b>		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11/4/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Weller's Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Thurmont, Frederick, Maryland</b>
24. EMPLOYER'S NAME <b>R. E. Dailey &amp; Son</b>		25. DATE REC'D. BY REGISTRAR <b>NOV 12 1985</b>	
26. ADDRESS <b>615 E. Main Street P.A. Thurmont, Md. 21788</b>		27. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

870508



RECEIVED



11/2/80

345042

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LORENE H MASSIE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 29 1985</b>		2b. HOUR <b>1:00 A.M.</b>
3. SEX <b>female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 24, 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Alabama</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>waitress</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>restaurant</b>
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Hagerstown</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>
13e. STREET ADDRESS / ZIP CODE <b>11 West Baltimore Street 21740</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>James W. Hargrove</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ada M. Vanhoozier</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		16b. SOCIAL SECURITY NO. <b>410-07-9572</b>		17. INFORMANT ADDRESS <b>Mrs. Anna R. Poole, Hagerstown, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lung Carcinoma with</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>liver metastases</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic obstructive pulmonary disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/29</b> 19 <b>85</b> that (I) (we) lost saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Dr. Annade / S. Anrade</b>		DEGREE		22c. DATE SIGNED <b>11/29/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FRANCISCO ANRADE</b>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>Dec. 2, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Washington, MD.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740</b>				25. DATE REC'D. BY REGISTRAR <b>DEC 05 1985</b>	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MUSIC

Jazz





337097

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Madge K. McConnell</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11/19/85</b>			2b. HOUR MIN. <b>1205</b> M					
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>03-15-1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE COUNTRY <b>S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington Co.</b> MD.					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Co. Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Registered Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Penna.</b>			13b. COUNTY <b>Franklin</b>		13c. CITY OR TOWN <b>Waynesboro</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>99999</b> <b>99999</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Louis A. Kennerly</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucille Smoak</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>212-24-4592</b>	
17. INFORMANT ADDRESS <b>Mr. Frank S. McConnell</b>			17. INFORMANT ADDRESS <b>Waynesboro, Pa. 17268</b>			17. INFORMANT ADDRESS <b>9230 Meadowbrook Dr.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of breast with</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Osseous metastases</b>											
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Osseous metastases</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
9a. DATE OF OPERATION			19a. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/6</b> , 19 <b>85</b> , to <b>11/19</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>11/19</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22a. SIGNATURE <b>Frederic H. Kass III</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>11/19/85</b>		
22a. PHYSICIAN'S NAME (TYPE OR PRINT)			22b. ADDRESS <b>1825 Howell Rd Hagerstown Md</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11/21/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Burns Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Waynesboro Franklin Pa.</b>				
24. FUNERAL DIRECTOR NAME <b>Grove Funeral Home</b>			24b. ADDRESS <b>505 Broad St Waynesboro Pa. 17268</b>			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>NOV 25 1985</b>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201





322006

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DONALD</b>			FIRST MIDDLE LAST <b>MCCORMICK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov 2, 1985</b>			2b. HOUR <b>11 P</b> M		
3. SEX <b>MALE</b>			4. RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>June 15 1917</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.		
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Potomac 11 W. Baltimore St. Towers</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Security Officer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>			13c. CITY OR TOWN <b>Hagerstown</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Peter James</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cecelia Nora Lynch</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>218-30-9502</b>		
17. INFORMANT ADDRESS <b>Hag. Md.</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension Cardio-vascular disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>years</b> <b>years</b>			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>July</b> 19 <b>83</b> , to <b>Nov. 2</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>June 24</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE <b>John A. Moran</b> DEGREE <b>M.D.</b>			22c. DATE SIGNED <b>11/4/85</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN A. MORAN</b>			22e. ADDRESS <b>215 W. Washington St., Hagerstown, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11-5-85</b>			23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Cath. Cem</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balt. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Gerald N. Minnich</b>			ADDRESS <b>Hagerstown, Maryland</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 12 1985</b>			25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

000000



322028

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Harry Crosby McCulloch</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 5 85</b>			2b. HOUR <b>11:30 AM</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 12, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington Co., MD.</b>				
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Co. Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>farm impl. dealer</b>		12b. KIND OF BUSINESS OR <b>Mach.</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Pa.</b>		13b. COUNTY <b>Franklin</b>		13c. CITY OR TOWN <b>Mercersburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>12241 Sylvan Dr.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter C. McCulloch</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rachel Irene McKee</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>171-28-5841</b>		17. INFORMANT <b>12219 Sylvan Dr. John J. McCulloch Mercersburg, Pa.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach with</b> DUE TO, OR AS A CONSEQUENCE OF <b>Liver Metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>19 months</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										
9a. DATE OF OPERATION			9b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>12/79</b> , 19____, to <b>11/5/85</b> , 19____, that (I) (we) lost saw the deceased alive on <b>11/5/85</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Frederic H. Kass III</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/5/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS <b>1825 Howell Road, Hagerstown Md</b>		22f. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Frederic H. Kass III</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11/8/85</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Methodist Cem. of Little Cove</b>			23d. LOCATION Twp. COUNTY STATE <b>Franklin Pa.</b>	
24a. SIGNATURE OF REGISTRAR <b>J. M. Rimmer</b>			ADDRESS <b>17236 Mercersburg, Pa.</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 12 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John J. McCulloch</b>		

of 1917

Washington Co. Wash. D.C.

1917

1917



1917

1917

1917

333032

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME Charles Robert MEHAFFEY				2a. DATE OF DEATH 11-17-85 11-17-85 8:50 AM	
3. SEX M male		4. RACE White		5. DATE OF BIRTH 9-6-21	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash Co. Hosp.		9. BALTIMORE CITY OR COUNTY OF DEATH Wash Co. Washington MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dispatcher		12b. KIND OF BUSINESS OR INDUSTRY State Rd.			
13a. STATE MD		13b. COUNTY Wash		13c. CITY OR TOWN Hagerstown	
14. FATHER'S NAME Harvey D. Mehafeff		15. MOTHER'S MAIDEN NAME Grace Dale		13e. STREET ADDRESS / ZIP CODE 63 Broadway 21740	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) HW 11 217-12-2252		17. INFORMANT Mrs. Margaret R. Mehafeff Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A RESULT OF <u>Chronic respiratory failure</u> (b) <u>from chronic obstructive pulmonary disease</u> (c) <u>from chronic obstructive pulmonary disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10-5-85 to 11-16-85, that (I) (we) last saw the deceased alive on 11-16-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.					
22b. SIGNATURE Handwritten signature		DEGREE		22c. DATE SIGNED 11-16-85	
22d. PHYSICIAN'S NAME (PRINT) E. R. Bradizatal		22e. ADDRESS 382 Cedar Creek, Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 19, 1985		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Memorial Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash, Md.					
24. FUNERAL DIRECTOR NAME Davis Funeral Home Smithsburg, Md.				25a. DATE REC'D. BY REGISTRAR NOV 21 1985	
				25b. REGISTRAR'S SIGNATURE John Davidson-Randall	





326092

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

2a. DECEASED NAME (TYPE OR PRINT) <b>ROY Lee METZ</b>			2b. DATE OF DEATH MONTH <b>11</b> DAY <b>15</b> YEAR <b>85</b>			2c. HOUR <b>AM</b>			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH <b>September</b> DAY <b>9</b> YEAR <b>1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>barber</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>self-employed</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>24 East Lincoln Avenue 21740</b>	
14. FATHER'S NAME FIRST <b>Victor</b> MIDDLE <b>Milton</b> LAST <b>Metz</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Ada</b> MIDDLE <b></b> LAST <b>Miller</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218-30-9208A</b>		17. INFORMANT ADDRESS <b>Mrs. Olive Metz, Hagerstown, Maryland</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIORESPIRATORY ARREST**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) **CEREBROVASCULAR ACCIDENT**

DUE TO, OR AS A CONSEQUENCE OF

(c) APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**24 hours**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: **Hypertension**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>July 1978</b> to <b>11-15-85</b> , that (I) (we) last saw the deceased alive on <b>11-14-85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we had not viewed the body after death.)							
22b. SIGNATURE <b>[Signature]</b>				DEGREE <b></b>		22c. DATE SIGNED <b>11-16-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>Nov. 18, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Hagerstown, Wash.</b> COUNTY <b>Maryland</b> STATE <b></b>	
24. FUNERAL DIRECTOR <b>MINNICH FUNERAL HOME</b> NAME <b>415 East Wilson Blvd., Hagerstown, Maryland 21740</b> ADDRESS <b></b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 20 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

350033  
MINI  
20% COTTON & CO

328203

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth Naoma Metz		2a. DATE OF DEATH MONTH DAY YEAR 11-24-85		2b. HOUR 2:30 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 17, 1903	
6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1144 Luther Dr. 21740			
14. FATHER'S NAME FIRST MIDDLE LAST Daniel T. Sensenbaugh		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dessie Shrader			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-22-8181		17. INFORMANT ADDRESS Mr. Carson P. Metz, Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Left middle cerebral thrombosis with Rt. hemiplegia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from July 1968 to 11-24-85, that (I) (we) last saw the deceased alive on 11-23-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE ME. Byrkit		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-24-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M.E. Byrkit		22e. ADDRESS Williamspood Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Nov. 27, 1985		23c. NAME OF CEMETERY OR CREMATORY Manor Church Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Tilghmanton, Wash., Maryland					
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME		24b. ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740		25a. DATE REC'D. BY REGISTRAR NOV 28 1985	
25b. REGISTRAR'S SIGNATURE					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

60223E

20% COTTON 100% COTTON

WALKER-HILL



100% COTTON

336077

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the funeral director's office. Pages 3 and 4 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Charles Leonard Miller</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 22, 1985</b>			2b. HOUR M <b>M</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 8, 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD				
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7 East Washington Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>City of Hagerstown</b> MD		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>21740</b> <b>7 East Washington Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ruben Lee Miller</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nellie B. Hebb</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-09-1482</b>			17. INFORMANT ADDRESS <b>P.O. Box 124</b> <b>Gerrardstown W. Va.</b>							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF RECTUM</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>									
DUE TO, OR AS A CONSEQUENCE OF (c) <b>CONGESTIVE HEART FAILURE, COMPENSATED</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DIS. - ATRIAL FIB. CHRONIC</b>									
19a. DATE OF OPERATION <b>9/9/85</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RECTAL CANCER</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/18</b> , 19 <b>77</b> , to <b>11</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (they) (did not) view the body after death.									
22b. SIGNATURE <b>R.V. SARAMPOTE</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/23/85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R.V. SARAMPOTE</b>		22e. ADDRESS <b>879 Commonwealth Ave Hagerstown, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-25-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Washington, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>A.K. Coffman Funeral Home, Inc.</b>		ADDRESS <b>Hagerstown, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

BP

3

308190

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified of such.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR										
REG. NO.										
1. DECEASED NAME (TYPE OR PRINT) Edward Ross Miller, Jr.			2a. DATE OF DEATH MONTH DAY YEAR November 25, 1985			2b. HOUR 6:45A <sup>M</sup>				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 24, 1985		6. AGE (IN YEARS LAST BIRTHDAY) 61		7. UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt.2 Box# 171 (Western Pike)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steamfitter		12b. KIND OF BUSINESS OR INDUSTRY Construction		
13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt.2 Box#171 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Ross Miller, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Irene							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. WW 11 220-16-2264		17. INFORMANT ADDRESS Katherine Miller (item 13 above)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Prostate</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Prostate</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>1 yr?</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Aneurysm</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the deceased) attended the deceased from <u>Aug. 21, 1975</u> to <u>Nov. 25, 1985</u> , that (I) (we) last saw the deceased alive on <u>11-20-85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Max E. Byrkit</u>			DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11-25-85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Max E. Byrkit, M.D.			22e. ADDRESS 28 W. Potomac St. Williamsport, Maryland 21795							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 27, 1985		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Washington Maryland			
24. FUNERAL DIRECTOR NAME Major M. Osborne Williamsport, MD 21795			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 2 1985							

BP



1.1.1.1

338189

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		HOUR MIN.	
James M Minnick		11 26 85		6 <sup>10</sup> A M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	white	MONTH DAY YEAR	75 YRS	MONTHS	DAYS
		03 06 1910		HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia	USA	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Washington MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Hagerstown	Washington County Hospital		Security Officer		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
Maryland	Washington	Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		424 S. Potomac St. 21740	
Samuel C. Minnick		Virgie M. Summers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		W.W.II		Louise M. Minnick, Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest					
DUE TO, OR AS A CONSEQUENCE OF					
(b) Respiratory Insufficiency / Failure					
DUE TO, OR AS A CONSEQUENCE OF					
(c) Chronic Obstructive Pulmonary Disease					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
Arteriosclerotic Heart Disease - Diabetes Mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					
22a. I certify that (I) (this hospital) attended the deceased from 14 Sept. 1981, to 26 Nov. 1985, that (I) (we) lost					
saw the deceased alive on 20 Nov. 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
W.N. Fender		MD		26 Nov. 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
W.N. Fender		138 E. Antietam St. Hagerstown Md 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
burial		Nov. 29, 1985		Rest Haven Cemetery	
				23d. LOCATION	
				CITY OR TOWN COUNTY STATE	
				Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME MINNICH FUNERAL HOME		DEC 2 1985			
415 E. Wilson Blvd., Hagerstown, Md. 21740					

611878



30% COLONY BIRDS

WIAVAFH

322002

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove attachments. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, this medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>PAUL LEROY MINNICK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11/8/85</b>		2b. HOUR <b>7:05 a.m.</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8/1/1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Hagerstown, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10. CITY OR TOWN OF DEATH <b>Boonsboro, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Reeders Memorial Home</b>		12a. OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cabinet Maker Woodworker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Organ Mfg.</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Boonsboro</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Minnick</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marjorie Unknown</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>W. W. Two 219- 14- 9918</b>	
17. INFORMANT <b>A Mrs. Helen E. Minnick, Boonsboro, Md.</b>		18. ADDRESS <b>108 S. Main St.</b>		19. DATE OF OPERATION <b>11/8/85</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>11/5/85</b> to <b>11/8/85</b> , that (I) (we) lost saw the deceased alive on <b>11/5/85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) did not view the body after death.	
22b. SIGNATURE <b>Dr. R. L. Kugler</b>		22c. ADDRESS <b>P. O. Box 246 Keedysville, Md. 21756</b>		22d. DATE SIGNED <b>11/8/85</b>		22e. DATE REC'D. BY REGISTRAR	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-10-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Boonsboro, Wash. Co., Md.</b>	
24. FUNERAL DIRECTOR NAME <b>John H. Bast, Jr.</b>		24b. ADDRESS <b>Boonsboro, Md. 21713</b>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>John H. Bast, Jr.</b>	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Respiratory failure due to pneumonia**

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **Bilateral massive CVA's**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Hypertension**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**2 months**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTINUING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

123000

John A. West, Jr. Boonshoro, W. Va.  
11-10-85 Boonshoro Cemetery  
Boonshoro, W. Va. Co., W. Va.



100% COTTON  
CHIFFON

Yes  
... 212-14-2018 A Mrs. Helen J. Minnick, Boonshoro, W. Va.  
108 S. Main St.  
Minnick

Harryland  
Washington Boonshoro  
108 S. Main St. 2115  
Green Hill  
Oodmoker  
Washington

...  
...  
...

322168

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Lilly May MOHLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11/10/85</b>		2b. HOUR <b>9:50pM</b>		
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 29, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Ravenwood Lutheran Village</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Washington</b>		13c. CITY OR TOWN <b>Maugansville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George D. Aikens</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah McCormick</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO.	
17. INFORMANT ADDRESS <b>Lois Ewan, Maugansville, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Acute UTI</b> <b>ASCVD</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Several days</b> <b>Yr.</b>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Female Dehydration</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 19 <b>83</b> , to <b>11-7</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>11-7</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>W. B. KAHN</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22c. DATE SIGNED <b>11-11-85</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. B. KAHN</b>		22e. ADDRESS <b>1933 Va. Ave. Hagerstown, MD</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>	
23b. DATE <b>Nov. 13, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Maryland</b>		24. FUNERAL DIRECTOR NAME <b>MINNICH FUNERAL HOME</b> ADDRESS <b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>	
25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1985</b>		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	

221113



NOV 1941

MINIATURE

100% COTTON LISTS

10/10/41

10/10/41

2000

10/10/41

10/10/41



325105

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Eleanor Ruth Muise</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 9, 1985</b>		2b. HOUR <b>12:00am</b>					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 9, 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Massachusetts</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bookkeeper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Funkstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>40 Frederick Road 21734</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ralph E. Edmunds</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Isabelle Marie Tochtermann</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>018-14-7924</b>		17. INFORMANT <b>Gilbert P. Muise</b>		ADDRESS <b>P.O. Box 7243 - APO New York 09012</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Gastrointestinal hemorrhage</b> (c) <b>Atherosclerotic cardiovascular disease</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Emphysema.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>11/7</b> , 19 <b>85</b> , to <b>11/9</b> , 19 <b>85</b> , that (I) <del>(was)</del> lost saw the deceased alive on <b>11/9</b> , 19 <b>85</b> , and that in (my) <del>(own)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.										
22b. SIGNATURE <b>George Newman II M.D., M.D.</b>					DEGREE TENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/9/85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>George C. Newman II</b>					22e. ADDRESS <b>1825 Howell Road, Hagerstown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>11-10-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Crematorium</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Smithsburg, Wash., Md.</b>			
24. FUNERAL DIRECTOR NAME <b>A.K. Coffman Funeral Home, Inc.</b>					ADDRESS <b>Hagerstown, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>Nov 15 1985</b>			
25b. REGISTRAR'S SIGNATURE <b>J. A. ...</b>										

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

323105

November 2, 1962 12:00pm

Washington County Hospital  
Washington County  
New York  
12-14-1962  
Box 1245 - 120  
New York, New York 10010



12-14-1962  
Box 1245 - 120  
New York, New York 10010

337038

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be given to the physician, 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the physician is filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ARTHUR M. NEWCOMER</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 22, 1985</b>		2b. HOUR <b>6:46 A.M.</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 4, 1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Colton Villa Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Prick Co.</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Md.</b>	13b. COUNTY <b>Wash.</b>	13c. CITY OR TOWN <b>Hagerstown</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Rt 5 21740</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter B. Newcomer</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice Mae Martin</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>214-09-1193</b>		17. INFORMANT ADDRESS <b>Mrs. Mildred C. Patterson Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>congenital heart failure</b> DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Abdul Waheed, M.D.</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-22-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <b>1610 Oak Hill Ave. Hagerstown, Md 21740</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 25, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Lutheran Cem.</b>	
23d. LOCATION (CITY OR TOWN) <b>Leitersburg, Wash, Md.</b>		23e. STATE <b>Md.</b>		23f. ZIP CODE	
24. FUNERAL DIRECTOR NAME <b>Dennis L. Davis</b>		24b. ADDRESS <b>Smithsburg, Md.</b>		25a. DATE REC'D. BY REGISTRAR	
25b. REGISTRAR'S SIGNATURE <b>John L. Davis</b>		25c. DATE <b>NOV 27 1985</b>			

BP

1000000

AT THE

of the

of the

of the

of the

of the

of the

of the

of the

of the

of the

of the

of the

of the

of the

of the

1000000

337088

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

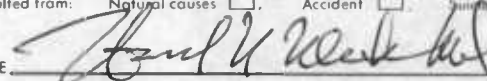

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M
 BP  
DHMH - 17  
(VR A15 ME (5))

 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

 1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Michael Edgar Nokes</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>Nov. 20, 1985</b>			2b. HOUR <b>12p</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 19, 1939</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>46</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD <b>November 20, 1985</b>		2d. HOUR <b>1:45</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b>	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>708 Summit Avenue</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cabinet Maker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Furniture C.</b>
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>708 Summit Avenue</b>		13f. STREET ADDRESS <b>21740</b>		13g. STREET ADDRESS <b>708 Summit Avenue</b>		13h. STREET ADDRESS <b>21740</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Edward Nokes Jr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maude Rebecca Angevine</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>220-34-0096</b>		17. INFORMANT <b>Pamela J. Ott</b>		17b. ADDRESS <b>1750 Garden Lane Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>(E-955) Gunshot wound to head</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12 P.M. Nov. 20, 1985</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>self-inflicted gunshot wound to head</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>at home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>708 Summit Ave., Hag. Wash., Md.</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE 		TITLE (SPECIFY) <b>Deputy</b>		MEDICAL EXAMINER		DATE SIGNED <b>11/20/85</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Howard N. Weeks, M.D.,</b>		ADDRESS <b>580 Northern Ave., Hag. Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (b) <b>Burial</b>		23b. DATE <b>11-22-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Washington, Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>A.K. Coffman Funeral Home, Inc.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 25 1985</b>		25b. REGISTRAR'S SIGNATURE 			





324095

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>Lloyd</u> <u>Harless</u> <u>Norris</u>			2a. DATE OF DEATH MONTH <u>11</u> DAY <u>8</u> YEAR <u>85</u>			2b. HOUR <u>10</u> <u>49</u> <u>P</u> M							
3 SEX <u>male</u>		4 RACE <u>white</u>		5. DATE OF BIRTH MONTH <u>July</u> DAY <u>15</u> YEAR <u>1905</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>80</u> YRS.		7. IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		8. IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Washington</u> MD.							
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington County Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>textile</u>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <u>Virginia</u>				13b. COUNTY <u>Rixeyville</u>		13c. CITY OR TOWN <u>Rixeyville</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>Route 1</u> <u>99999</u>			
14. FATHER'S NAME FIRST <u>George</u> MIDDLE <u>W.</u> LAST <u>Norris</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Mattie</u> MIDDLE <u>B.</u> LAST <u>Deavers</u>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>		16b. SOCIAL SECURITY NO. <u>229-05-1296</u>		17. INFORMANT ADDRESS <u>Bradley Funeral Home, Luray Virginia</u>									
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Chronic Obstructive Pulmonary Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Congestive Heart Failure</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u>			
										<u>10 yrs.</u>			
										<u>10 yrs.</u>			
MEDICAL CERTIFICATION													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from <u>1-10</u> , 19 <u>77</u> , to <u>11-8</u> , 19 <u>85</u> , that (1) (we) last saw the deceased alive on <u>11-8</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>C. F. Hess M.D.</u>			DEGREE			22c. DATE SIGNED <u>11-9-85</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>C. F. Hess M.D.</u>			22e. ADDRESS <u>Smithsburg, MD. 21783</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>			23b. DATE <u>November 8, 1985</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>			23d. LOCATION CITY OR TOWN COUNTY STATE <u>Rixeyville, Virginia</u>				
24. FUNERAL DIRECTOR NAME <u>MINNICH FUNERAL HOME</u> ADDRESS <u>415 E. Wilson Blvd. Hagerstown, Maryland 21740</u>						25a. DATE REC'D. BY REGISTRAR <u>NOV 15 1985</u>						25b. REGISTRAR'S SIGNATURE <u>John Pauline Rindella</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



331032



REPT. N. 1100 FOR

REPT. N. 1100 FOR

337012

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Mildred Elizabeth OFFORD					2a. DATE OF DEATH MONTH DAY YEAR November 23, 1985					2b. HOUR 8:55 P.M.
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR October 25, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.				
10. CITY OR TOWN OF DEATH Maryland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12 South Walnut Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 3a. STATE Maryland					13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Archibald R. Shafer					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Hazel Sauerwein					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 230-32-6949		17. INFORMANT ADDRESS Mrs. Mary Crim, Vanceburg, Kentucky						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>POSSIBLE ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ATHERO SCLEROTIC CARDIOVASCULAR DISEASE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>STATUS POST LEFT CEREBROVASCULAR ACCIDENT</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE m-shafi					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11.25.85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHAFF					22e. ADDRESS 138 E Antietam ST Hagerstown MD 21740					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Nov. 26, 1985		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland				
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740					25a. DATE REC'D. BY REGISTRAR NOV 29 1985		25b. REGISTRAR'S SIGNATURE			

BP

922

333080

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) <b>Agnes Lillian OLIVER</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 23 1985</b>		2b. HOUR <b>4:25</b> M	
3. SEX <b>female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 15, 1900</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Texas</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON</b> MD.		
10. CITY OR TOWN OF DEATH <b>WILLIAMSPORT</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WILLIAMSPORT NURSING HOME</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Oklahoma</b>		13b. COUNTY	13c. CITY OR TOWN <b>Enid</b>	13d. STREET ADDRESS <b>2211 West Oklahoma Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Will Atwood</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Josephine Bruce</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>440-40-8122</b>		17. INFORMANT ADDRESS <b>Mrs. Josephine Benton, Takoma Park, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>SEPSIS</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIOVASCULAR DISEASE.</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 8</b> 19 <b>83</b> , to <b>NOVEMBER 23</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>NOV 23</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John R. Melnick</b>		DEGREE <b>MD</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John R. Melnick</b>		22e. ADDRESS <b>16220 Frederick Road Gaithersburg, MD 20760</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>Nov. 24, 1985</b>	23c. NAME OF CEMETERY OR CREMATORY <b>George Washington Cemetery Adelphi, Maryland</b>		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME <b>MINNICH FUNERAL HOME</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John R. Melnick</b>	
415 East Wilson Blvd., Hagerstown, Maryland 21740					

BP

A

2

1

326127

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 may be retained by the funeral director, page 3 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 2 6 4 4

REG. NO.

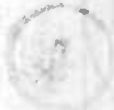
1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Haskell W Orndoff</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11 15 85</i>			2b. HOUR <i>1:30 PM</i>				
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12 25 1917</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>67</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Davis, W. Va.</i>		9b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.				
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Gear Grinder</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Truck Mfg.</i>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>			13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Funkstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>17 E. Green St. 21734</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Earl S. Orndoff</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Vercie Thompson</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES) <i>W. W. Two</i>		16b. SOCIAL SECURITY NO. <i>220-18-1977</i>		17. INFORMANT <i>Mrs. Bonnie Jean Hamsher, Chambersburg, Pa.</i>				ADDRESS <i>810 Bowman Rd.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>From Tuberculosis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Tuberculosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic Intestinal Polyp Stool</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>8:25 P.M. 19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>820</i>				
22a. I certify that (i) this hospital attended the deceased from <i>11-15-85</i> 19 <i>85</i> , to <i>11-15-85</i> 19 <i>85</i> , that (ii) (we) last saw the deceased alive on <i>11-15-85</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (iii) (we) did not see the body after death.										
22b. SIGNATURE <i>E. J. Henderson</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11-16-85</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>E. J. Henderson</i>						22e. ADDRESS <i>387 W. W. Cleveland, Hagerstown</i>				
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>			23b. DATE <i>11-19-85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Lawn Mem. Park</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown, Wash. Co., Md.</i>		
24. FUNERAL DIRECTOR <i>John H. Bast, Jr. Boonsboro, Md. 21713</i>						25a. DATE REC'D. BY REGISTRAR <i>NOV 19 1985</i>				
						25b. REGISTRAR'S SIGNATURE <i>John Henderson</i>				

MEDICAL CERTIFICATION

326132

10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60  
61  
62  
63  
64  
65  
66  
67  
68  
69  
70  
71  
72  
73  
74  
75  
76  
77  
78  
79  
80  
81  
82  
83  
84  
85  
86  
87  
88  
89  
90  
91  
92  
93  
94  
95  
96  
97  
98  
99  
100



101  
102  
103  
104  
105  
106  
107  
108  
109  
110  
111  
112  
113  
114  
115  
116  
117  
118  
119  
120  
121  
122  
123  
124  
125  
126  
127  
128  
129  
130  
131  
132  
133  
134  
135  
136  
137  
138  
139  
140  
141  
142  
143  
144  
145  
146  
147  
148  
149  
150  
151  
152  
153  
154  
155  
156  
157  
158  
159  
160  
161  
162  
163  
164  
165  
166  
167  
168  
169  
170  
171  
172  
173  
174  
175  
176  
177  
178  
179  
180  
181  
182  
183  
184  
185  
186  
187  
188  
189  
190  
191  
192  
193  
194  
195  
196  
197  
198  
199  
200

201  
202  
203  
204  
205  
206  
207  
208  
209  
210  
211  
212  
213  
214  
215  
216  
217  
218  
219  
220  
221  
222  
223  
224  
225  
226  
227  
228  
229  
230  
231  
232  
233  
234  
235  
236  
237  
238  
239  
240  
241  
242  
243  
244  
245  
246  
247  
248  
249  
250  
251  
252  
253  
254  
255  
256  
257  
258  
259  
260  
261  
262  
263  
264  
265  
266  
267  
268  
269  
270  
271  
272  
273  
274  
275  
276  
277  
278  
279  
280  
281  
282  
283  
284  
285  
286  
287  
288  
289  
290  
291  
292  
293  
294  
295  
296  
297  
298  
299  
300

301  
302  
303  
304  
305  
306  
307  
308  
309  
310  
311  
312  
313  
314  
315  
316  
317  
318  
319  
320  
321  
322  
323  
324  
325  
326  
327  
328  
329  
330  
331  
332  
333  
334  
335  
336  
337  
338  
339  
340  
341  
342  
343  
344  
345  
346  
347  
348  
349  
350  
351  
352  
353  
354  
355  
356  
357  
358  
359  
360  
361  
362  
363  
364  
365  
366  
367  
368  
369  
370  
371  
372  
373  
374  
375  
376  
377  
378  
379  
380  
381  
382  
383  
384  
385  
386  
387  
388  
389  
390  
391  
392  
393  
394  
395  
396  
397  
398  
399  
400

401  
402  
403  
404  
405  
406  
407  
408  
409  
410  
411  
412  
413  
414  
415  
416  
417  
418  
419  
420  
421  
422  
423  
424  
425  
426  
427  
428  
429  
430  
431  
432  
433  
434  
435  
436  
437  
438  
439  
440  
441  
442  
443  
444  
445  
446  
447  
448  
449  
450  
451  
452  
453  
454  
455  
456  
457  
458  
459  
460  
461  
462  
463  
464  
465  
466  
467  
468  
469  
470  
471  
472  
473  
474  
475  
476  
477  
478  
479  
480  
481  
482  
483  
484  
485  
486  
487  
488  
489  
490  
491  
492  
493  
494  
495  
496  
497  
498  
499  
500

501  
502  
503  
504  
505  
506  
507  
508  
509  
510  
511  
512  
513  
514  
515  
516  
517  
518  
519  
520  
521  
522  
523  
524  
525  
526  
527  
528  
529  
530  
531  
532  
533  
534  
535  
536  
537  
538  
539  
540  
541  
542  
543  
544  
545  
546  
547  
548  
549  
550  
551  
552  
553  
554  
555  
556  
557  
558  
559  
560  
561  
562  
563  
564  
565  
566  
567  
568  
569  
570  
571  
572  
573  
574  
575  
576  
577  
578  
579  
580  
581  
582  
583  
584  
585  
586  
587  
588  
589  
590  
591  
592  
593  
594  
595  
596  
597  
598  
599  
600

601  
602  
603  
604  
605  
606  
607  
608  
609  
610  
611  
612  
613  
614  
615  
616  
617  
618  
619  
620  
621  
622  
623  
624  
625  
626  
627  
628  
629  
630  
631  
632  
633  
634  
635  
636  
637  
638  
639  
640  
641  
642  
643  
644  
645  
646  
647  
648  
649  
650  
651  
652  
653  
654  
655  
656  
657  
658  
659  
660  
661  
662  
663  
664  
665  
666  
667  
668  
669  
670  
671  
672  
673  
674  
675  
676  
677  
678  
679  
680  
681  
682  
683  
684  
685  
686  
687  
688  
689  
690  
691  
692  
693  
694  
695  
696  
697  
698  
699  
700

Washington County Capital

Washington County Capital

Washington County Capital

Washington County Capital

Washington County Capital

Washington County Capital

Washington County Capital

Washington County Capital

Washington County Capital

Washington County Capital



312025

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 2 6 4 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Sharon A Partin</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 02 85</b>			2b. HOUR <b>7:30pm</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>04 19 44</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>41</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		9. CITIZEN OF WHAT COUNTRY? <b>US</b>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.			
12. CITY OR TOWN OF DEATH <b>Hagerstown</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Western Maryland Center</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE <b>MD.</b> 16b. COUNTY <b>Frederick</b> 16c. CITY OR TOWN <b>Mt. Airy</b>			17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18. STREET ADDRESS / ZIP CODE <b>5927 Woodville Road 21771</b>				
19. FATHER'S NAME FIRST MIDDLE LAST <b>Nathan Austin Emmons</b>			20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gertrude Massey</b>						
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		22. SOCIAL SECURITY NO. <b>213-40-6425</b>		23. INFORMANT ADDRESS <b>A. E. Partin, Item 13</b>					
24. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetic Nephropathy</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>									
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes Mellitus</b> <b>Years</b>									
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypoxic Encephalopathy</b> <b>Years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>1a</b>									
25. DATE OF OPERATION			26. CONDITION FOR WHICH OPERATION WAS PERFORMED			27. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
32. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			34. LOCATION STREET CITY OR TOWN COUNTY STATE			
35. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9-13</b> , 19 <b>85</b> , to <b>11-2</b> , 19 <b>85</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11-2</b> , 19 <b>85</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> view the body after death.									
36. SIGNATURE <b>Kyung S. Kim, M.D.</b>						37. DEGREE <b>M.D.</b>		38. DATE SIGNED <b>11-2-85</b>	
39. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kyung S. Kim, M.D.</b>						40. ADDRESS <b>1500 Pennsylvania Avenue Hagerstown, MD 21740</b>			
41. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			42. DATE <b>Nov. 5, 1985</b>		43. NAME OF CEMETERY OR CREMATORY <b>Westview</b>		44. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		
45. FUNERAL DIRECTOR <b>Orin L. Molesworth, P.A., Damascus, Md.</b>						46. DATE REC'D. BY REGISTRAR <b>NOV 05 1985</b>		47. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

3

85

85

85

85

85

85

85

85

85

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

312032

11 05 35 2:30P

11 05 35 2:30P

11 05 35 2:30P

11 05 35 2:30P

11 05 35 2:30P

11 05 35 2:30P

11 05 35 2:30P

11 05 35 2:30P

11 05 35 2:30P

11 05 35 2:30P

11 05 35 2:30P

11 05 35 2:30P

11 05 35 2:30P

11 05 35 2:30P

11 05 35 2:30P

11 05 35 2:30P

11 05 35 2:30P

318167

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ALL INFORMATION ON THIS FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT IF BURIAL. LAND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

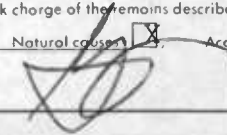

127/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Leann Renee Paul</b>			2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> <b>11 1 19 85</b>			2b. HOUR M <input type="checkbox"/> M <input type="checkbox"/> <b>7:20A</b>		
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>6</b> DAY <b>30</b> YEAR <b>85</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. <b>4</b>	IF UNDER 1 YR. MONTHS <b>4</b> DAYS <b>1</b>	IF UNDER 24 HRS. HOURS <b>1</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD MONTH <b>11</b> DAY <b>1</b> YEAR <b>19 85</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>				13b. CITY OR TOWN <b>Frederick</b>		13c. STREET ADDRESS <b>7905 Miles Lane Walkersville</b>		<b>21793</b>
14. FATHER'S NAME FIRST <b>Nathan</b> MIDDLE <b>Paul</b> LAST <b>Stull</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Michele</b> MIDDLE <b>Stull</b> LAST <b>Stull</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		(IF YES, GIVE WAR OR DATES) <b>None</b>		16b. SOCIAL SECURITY NO. <b>219-08-0631</b>		17. INFORMANT <b>Mrs. Michele Paul</b> ADDRESS <b>7905 Miles Lane Walkersville, Md. 21793</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sudden Infant Death Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. <b>Assistant</b> MEDICAL EXAMINER			DATE SIGNED <b>11/1/85</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Gregory R. Kauffman, M.D.</b>			ADDRESS <b>111 Penn St. Balto. MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11-5-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Marvin Chapel Cemetery</b>		23d. LOCATION CITY OR TOWN <b>New Market, Frederick, Md.</b> COUNTY _____ STATE _____	
24. FUNERAL DIRECTOR NAME <b>Smith, Keeney &amp; Basford</b> ADDRESS <b>Funeral Home 106 East Church St., Frederick, Md. 21701</b>					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE 	

NOV 02 1985

1941

James

1-30-37

White

Female

X

anyone

1941

at 7505 White Lane, Winchester

Winchester

1-30-37

anyone

1941

Winchester

1941

anyone

at 7505 White Lane, Winchester

1-30-37

anyone

anyone

Winchester, Va. 22701



1-30-37, Winchester, Va.

1-30-37

anyone

anyone, Winchester, Va.

1-30-37, Winchester, Va. 22701

326126

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Emma F. Perkins</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>November 16, 1985</i>		2b. HOUR <i>8:30A</i> M.			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>October 24, 1910</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>75</i> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Trego, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.		
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Rohrersville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Elmer H. Smith</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Nellie Jackson</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <i>No</i>		16b. SOCIAL SECURITY NO. <i>214-16-1966</i>		17. INFORMANT ADDRESS <i>Rfd. 1 Box 362</i> <i>Mrs. Patricia R. Shoemaker, Rohrersville, Md.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiorespiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Septic diverticular abscess</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Senile emphysema</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Andrew J. Gunn</i> M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/16/85</i> 8:30 AM		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Andrew J. Gunn</i>				22e. ADDRESS <i>100 Geeting Lane, Keedysville, Md. 21756</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11-19-85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Boonsboro Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Boonsboro, Wash. Co., Md.</i>		
24. FUNERAL DIRECTOR NAME ADDRESS <i>John H. Bast, Jr. Boonsboro, Md. 21713</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 19 1985</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

326126

November 10, 1902

Female  
Mingo, Md.  
Baltimore  
Maryland  
First  
H.  
Smith  
Hollis  
Jackson  
Box 102  
Mrs. Patricia B. Snowaker, Knoxville, Tenn.  
Box 102  
November 10, 1902

100 Easting Lane, Knoxville, Tenn. 37912

Butler 11-9-02 Bonanza Cemetery Bonanza, Tenn. Co., Tenn.

John R. Smith, Bonanza, Tenn. 37912



325077

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

MARGARET MARIE PICKETT

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARGARET MARIE PICKETT</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>November 9, 1985</b>				2b. HOUR <b>M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 18, 1985</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Colton Villa Nursing Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edgar Miller</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Stitley</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. (IF YES, NO WAR OR DATES) <b>705-10-4986</b>		17. INFORMANT ADDRESS <b>Carolyn M. Eichelberger Hagerstown, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Abdul Waheed</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/10/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ABDUL WAHEED MD</b>						22e. ADDRESS <b>1610- OAKHILL NE. HAG. MD 21740</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>11-13-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Thurmont, Frederick, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>A.K. Coffman Funeral Home, Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 15 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top two papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



State of Maryland  
County of Prince George's  
I, the undersigned, Clerk of the Circuit Court for the County of Prince George's, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of said Court.

3

HOW HIGH

WARRANT FOR ARREST  
State of Maryland  
County of Prince George's  
I, the undersigned, Clerk of the Circuit Court for the County of Prince George's, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of said Court.

336110

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Leah Kathryn Poe			2a DATE OF DEATH MONTH DAY YEAR 11 22 85			2b HOUR 115 PM	
3 SEX Female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 01 29 1903		6 AGE (IN YEARS (LAST BIRTHDAY)) 82 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10 CITY OR TOWN OF DEATH Hagerstown		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) seamstress	
12b KIND OF BUSINESS OR INDUSTRY clothing		21740					
13a STATE Maryland			13b COUNTY Washington		13c CITY OR TOWN Hagerstown		
14 FATHER'S NAME John W. Yeates			15 MOTHER'S MAIDEN NAME Eliza Jane Clopper				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b SOCIAL SECURITY NO. 173-03-2392-A		17 INFORMANT Mr. George Edward Poe, Hagerstown, Md.		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ventricular ectopy</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Dementia - severe</u>				

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			

22a I certify that (I) (this hospital) attended the deceased from 19 85 to 11/22, 19 85, that (I) (we) last saw the deceased alive on 11/22, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
--	--	--	--	--	--	--	--

22b SIGNATURE George Newman II Ph.D., M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED	
---	--	--	--	-----------------	--

22e PHYSICIAN'S NAME (TYPE OR PRINT) George Newman, II Ph.D., M.D.		22f ADDRESS 1825 Howell Road, Hagerstown, Maryland 21740					
---	--	---	--	--	--	--	--

23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b DATE Nov. 26, 1985		23c NAME OF CEMETERY OR CREMATORY Harbaugh's Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Rouzverville, Wash., Maryland	
--	--	---------------------------	--	--	--	--	--

24 FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME		25a DATE REC'D. BY REGISTRAR NOV 26 1985		25b REGISTRAR'S SIGNATURE	
---	--	---	--	---------------------------	--

415 East Wilson Blvd., Hagerstown, Maryland 21740	
---	--

01338



ADDITIONAL NOTION %000

11/1/41

11/1/41

338045

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3, -RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M
 BP \_\_\_\_\_  
 DHMH - 17  
 (VR A15 ME (1))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Carl Thomas Poffenberger</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 26 1985</b>		2b. HOUR <b>11 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 30, 1906</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>79</b> YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11 26 1985</b>		7d. HOUR <b>7 PM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.			
10. CITY OR TOWN OF DEATH <b>Fairplay</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rt. 1 Box# 97C</b>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Fairplay</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 1 Box# 97C</b>		21733	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Roy Poffenberger</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ada Colbert</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-36-4312</b>		17. INFORMANT ADDRESS <b>Dola V. Poffenberger (item 13 above)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary arrest 427</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last: (b) <b>Arteriosclerotic cardiovascular disease 429</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>Emphysema</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>[Signature]</b>				TITLE (SPECIFY) M.D. <b>Dept Ass't</b> MEDICAL EXAMINER				DATE SIGNED <b>11/26/85</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>P. K. D. M.D.</b>				ADDRESS <b>1610 Oak Hill Ave Hagerstown MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Nov. 30, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Williamsport Washington Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Major M. Osborne Williamsport, MD 21795</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 2 1985</b>		25b. REGISTRAR'S SIGNATURE			

*[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "The" and "and" are visible.]*

326129

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Edward L. Pomeroy</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 10 85</b>			2b. HOUR <b>11 49 AM</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 8 1925</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>0 0 0 0</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Treasurer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Whsl. Hardware</b>			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1416 Outer Court 21740</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Clarence Rex Pomeroy</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Martha Siepelmeyer</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 219-14-8612</b>		17. INFORMANT ADDRESS <b>Shirley R. Pomeroy same as 13</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CANCER TO RESP. ARTERY</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ADENOCARCINOMA of the lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>WITH METASTASIS</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>C. Wooster</b> M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>11/10/85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11-12-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown Wash. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Gerald N. Minnich</b>					305 N. Potomac St. ADDRESS <b>Hagerstown, Maryland</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	

MEDICAL CERTIFICATION

35  
211  
1

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy performed.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

036130



W. H. HANLEY

MOTION PICTURE



331023

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 2 6 5 2

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Louise Oakley PRICE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 21, 1985</b>		2b. HOUR <b>M</b>						
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>September 10, 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b>		IF UNDER 1 YEAR MONTHS DAYS <b>YRS</b>		IF UNDER 24 HRS HOURS MIN. <b>MIN.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON</b>					
10. CITY OR TOWN OF DEATH <b>Williamsport</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>118 N. Conococheague St.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>						13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Williamsport</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Carl Weimaster, Sr.</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Ann Paragoy</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>-----</b>		17. INFORMANT ADDRESS <b>Margaret Minnich (item 13 above)</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery disease</b>		<b>yrs</b>
	DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes M</b>		<b>yrs</b>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **no**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION <b>none</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>none 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>-</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>none</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>- - - - -</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov</b> , 19 <b>72</b> , to <b>Nov</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>Aug 21</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>WW Lesh</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-22-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William W. Lesh M.D.</b>				22e. ADDRESS <b>411 Division Avenue Hagerstown, Md.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 23, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Williamsport Washington Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Major M. Osborne Williamsport, MD 21795</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 25 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

GOVERNMENT OF CANADA  
MINISTER OF DEFENSE  
RUE DU CANAL, OTTAWA, K1P 5K6



Original signed

Colonel (retired) General

Retired

none

none

none

none

11-22-53

41 Division Avenue, New York, N.Y.

326026

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8532053

1. FOR  
STATE  
REGISTRAR

Raymond L

REG. NO.

1. DECEASED NAME  
(TYPE OR PRINT)

Raymond L Price

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  
11-13-85 6:24 PM

3. SEX

male

4. RACE

Caucasian

5. DATE OF BIRTH

12 16 1915

6. AGE (IN YEARS LAST BIRTHDAY)

69

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Pennsylvania

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Washington County MD.

10. CITY OR TOWN OF DEATH

Hagerstown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Washington County Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

cabinet maker

12b. KIND OF BUSINESS OR INDUSTRY

bank

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

N.J.

13b. COUNTY

Burlington

13c. CITY OR TOWN

Bass River

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

P.O. Box 187

99999

14. FATHER'S NAME

Samuel

MIDDLE

LAST

Price

15. MOTHER'S MAIDEN NAME

Matilda

MIDDLE

LAST

McKnight

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)

Yes ☒ NO ☐ UNKNOWN

W.W.II (Army)

16b. SOCIAL SECURITY NO.

210-09-1935

17. INFORMANT

Anna Price (wife)

ADDRESS

P.O. Box 187

New Gertma, N.J.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiogenic shock.

DUE TO, OR AS A CONSEQUENCE OF

(b) ACUTE MYOCARDIAL INFARCTION.

DUE TO, OR AS A CONSEQUENCE OF

(c) SEVERE, LABILE HYPERTENSION.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Chronic renal failure and gastrointestinal bleed.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 11-5, 1985, to 11-13, 1985, that (I) (we) last saw the deceased alive on 11-13, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

mshafi

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

11/13/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

SHAFI

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

burial

23b. DATE

Nov. 14, 1985

23c. NAME OF CEMETERY OR CREMATORY

Beverly Nat. Cemetery

23d. LOCATION

Beverly, Burlington, N. Y.

24. FUNERAL DIRECTOR MINNICH FUNERAL HOME

NAME

415 E. Wilson Blvd., Hagerstown, Md. 21740

ADDRESS

25. DATE REC'D BY REGISTRAR 25. REGISTRAR'S SIGNATURE

NOV 20 1985

John Davidson-Randall

328036



RECEIVED  
JAN 19 1941  
U.S. DEPT. OF JUSTICE

RECEIVED  
JAN 19 1941  
U.S. DEPT. OF JUSTICE

2

340024

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RUTH A Rice			2a. DATE OF DEATH MONTH DAY YEAR 11 30 85			2b. HOUR 6:50 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 23 1923		6. AGE (IN YEARS (LAST BIRTHDAY)) 62 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 240 S. Mulberry St. 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Morris Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Viola Poffenberger						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-24-7936		17. INFORMANT ADDRESS James. W. Rice same as 13					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Stroke</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Anterior Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Anterior Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs 40 hrs 7 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION 11-30-85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Temporary Pacemaker, AV Block			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>11-29</u> , 19 <u>85</u> , to <u>11-30</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>11-30</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11-30-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-3-85		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Wash. Md.			
24. FUNERAL DIRECTOR NAME Gerald N. Minnich Hagerstown, Maryland				305 N. Potomac St. ADDRESS		25a. DATE REC'D. BY REGISTRAR DEC 4 1985		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the medical examiner within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be immediately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ESDONG



336075

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Frederick Berkeley Rohrer</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 21, 1985</b>		2b. HOUR <b>10:45P</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>August 17, 1931</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Security, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Truck Driver</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Maryland</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Paul Rohrer</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Viola May Mc Allister</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>220-26-0725A</b>		17. INFORMANT ADDRESS <b>Dorothy I. Jones, Rfd. 3 Box 86 Boonsboro, Md. 21713</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Atherosclerotic cardiovascular disease with congestive heart failure</b> (c) <b>Diabetes mellitus - insulin dependent</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Bronchospasm, emphysema - severe, pneumonia</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPOST YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>2/22</b> , 19 <b>78</b> , to <b>11/21</b> , 19 <b>85</b> , that (he) (she) (we) lost the deceased alive on <b>11/21</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.					
22b. SIGNATURE <b>George Newman II M.D.</b>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>George Newman, II M. D.</b>				22e. ADDRESS <b>1825 Howell Rd. Hagerstown, Md. 21740</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-25-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Boonsboro, Wash. Co., Md.</b>		24. FUNERAL DIRECTOR <b>John H. Bast, Jr. Boonsboro, Md. 21713</b>			
25a. DATE RECD. BY REGISTRAR <b>NOV 27 1985</b>				25b. REGISTRAR'S SIGNATURE	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by a physician after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director's page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Paper and 2 should be filled with 272 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



355075

Frederick Berkeley Rohnert November 21, 1952 10:32

Male August 17, 1937 24

County, N. U. S. A. Washington

Washington County Hospital

Truck River

Maryland Washington Maryland

Paul Rohnert Viola No. 11152

550-28-0152A Evelyn I. Jones, Mrs. J. Box 80  
Boonsboro, Md. 21713

George Herman, II N. A. 1937 Boonsboro, Md. 21710

Boonsboro Cemetery Boonsboro, Md. 21710

John H. Jones, Jr. Boonsboro, Md. 21713 NOV 21 1952

322066

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>Robert W. Schmidt</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>11-7-85</u>			2b. HOUR <u>3:35</u> AM	
3. SEX <u>M</u>		4. RACE <u>W</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>2-1-03</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>82</u> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Washington</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Washington Co</u> MD.	
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Clearview Nursing Home</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Railroad</u>	
12b. KIND OF BUSINESS OR INDUSTRY <u>W. MD. R.R.</u>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <u>Md</u> 13c. COUNTY <u>Washington</u> 13d. CITY OR TOWN <u>Hagerstown</u> 13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13f. STREET ADDRESS / ZIP CODE <u>Rt 9, Box 203 21040</u>					
14. FATHER'S NAME FIRST MIDDLE LAST <u>William S. Schmidt</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Marie Lightsey</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>			
16b. SOCIAL SECURITY NO. <u>705-10-9585</u>		17. INFORMANT NAME ADDRESS <u>Catherine D. Schmidt #13</u>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(b) Chronic Obstructive Pulmonary Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Myocardial Infarction, Hypertension, atherosclerotic disease

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9/19/85</u> 19 <u>85</u> to <u>11/7/85</u> 19 <u>85</u> , that (I) <del>two</del> lost saw the deceased alive on <u>10/1/85</u> 19 <u>85</u> , and that in (my) <del>low</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> did not view the body after death.							
22b. SIGNATURE <u>Edson B. Moody</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/1/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Edson B. Moody MD</u>		22e. ADDRESS <u>RT #3 Box 163 Hagerstown, Md 21040</u>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>11-10-85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Sharpsburg Wash. Md.</u>	
24. FUNERAL DIRECTOR NAME <u>Gerald N. Minnich</u>		ADDRESS <u>305 N. Potomac St. Hagerstown, Maryland</u>		DATE RECEIVED BY REGISTRAR REGISTRAR'S SIGNATURE <u>11/12/85</u> <u>J. Davidson</u>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please receive carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

33168

20% COTTON FIBER  
MADE IN U.S.A.



326093

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM Franklin F. SEMENBAUGH</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11 16 85</b>		2b. HOUR <b>6:08 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 13 30</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>USA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON COUNTY HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>UK</b>	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>		13b. COUNTY <b>WASH.</b>		13c. CITY OR TOWN <b>SE. JAMES</b>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>GENERAL DELIVERY 21781</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>W. Reichard Sensenbaugh</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Madeline Grove</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Korean Confl 12 15 26 7938</b>		17. INFORMANT ADDRESS <b>Mrs. Vanette Sensenbaugh, St. James MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery disease, recent extensive</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>myocardial infarction, with severe left ventricular dysfunction</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9/24/85</b> , 19 <b>85</b> , to <b>11/16/85</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>11/16/85</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Thomas B. Haywood</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/16/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thomas B. Haywood MD</b>		22e. ADDRESS <b>645 E. First St. Hagerstown, Md. 21740</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>Nov. 19, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Manor Church Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Tilghmanton, Wash., Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>MINNICH FUNERAL HOME</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 20 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
415 E. Wilson Blvd., Hagerstown, Maryland 21740					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21 11

326094

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JEAN MARIE SHUPP</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11/14/85</b>		2b. HOUR <b>5:38 PM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASION</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 - 07 - 31</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASH. Co. - MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON COUNTY</b> MD.		
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON COUNTY HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Hagerstown</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Finley Clopper</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Virginia Hornbaker</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>William M. Shupp, Hagerstown, Maryland</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Anterior Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes Mellitus Type II</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>84</b> , to <b>Sept</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>Aug.</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Mary E. Money MD</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/15/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mary E. Money MD</b>		22e. ADDRESS <b>1708 Oak Hill Ave, Hagerstown, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>	23b. DATE <b>Nov. 18, 1985</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Mem. Park</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Maryland</b>		
24. FUNERAL DIRECTOR <b>MINNICH FUNERAL HOME</b> NAME ADDRESS <b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 20 1985</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified.



REGISTRATION NOTICE



10/1/82

Low, mid-range, and high range

10/1/82

Low, mid-range, and high range



331033

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>Susan S. Six</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11-21-85</b>				2b. HOUR <b>12<sup>47</sup> PM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 16 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Hagerstown</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. America</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington Co.</b> MD.					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1036 Brinker Dr. 21740</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John K. Jacobs</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-54-2387</b>		17. INFORMANT <b>David F. Six, Hagerstown, Md.</b>				ADDRESS			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic CVD</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Arteriosclerotic CVD &amp; right ventricular hypertrophy</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>years</b> <b>years</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AS WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>26 June 1961</b> to <b>date</b> , that (I) (we) last saw the deceased alive on <b>21 Nov 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death)											
22b. SIGNATURE <b>Richard T. Binford</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>21 Nov 85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Binford</b>				22e. ADDRESS <b>Hagerstown, Md</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>Nov. 23, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Long Meadow Ch. of Brethren Hagerstown, Wash., Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME <b>MINNICH FUNERAL HOME</b>				24b. ADDRESS <b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 25 1985</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BP

330453



338010

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Harlen Ever SMITH			2a. DATE OF DEATH MONTH DAY YEAR 11 19 85		2b. HOUR 1:46 P.M.
3. SEX MALE	4. RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR 7 5 1974	6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH WAS HINGTOWN COUNTY MD.		
10. CITY OR TOWN OF DEATH HAGERSTOWN, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CLEARVIEW NURSING HOME, INC.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer	12b. KIND OF BUSINESS OR INDUSTRY Farm	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST EMORY M SMITH			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie G. Miller		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WWI 220-16-3539		17. INFORMANT ADDRESS Mr. Ralph J. Smith Hagerstown, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 months
--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Central arteriosclerosis, arteriosclerotic heart disease, Parkinson's disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/7/85</u> to <u>11/19/85</u> , that (I) (we) last saw the deceased alive on <u>4/7/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.			

22b. SIGNATURE <u>Edson B. Moody M.D.</u>	DEGREE	22c. DATE SIGNED <u>11/19/85</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edson B. Moody	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22e. ADDRESS RT 3 Box 163 St. James, Md. 21781

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 22, 1985	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash. Md.
24. FUNERAL DIRECTOR Davis Funeral Home		25. DATE REGD. BY REGISTRAR NOV 27 1985	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		27. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained in the hospital or attending physician's office for 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

BP

DATE: 11/11/54

TO: Mr. J. Edgar Hoover

FROM: Mr. C. L. [illegible]

SUBJECT: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]



100-100000-1000



Very truly yours,

[illegible signature]

337011

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Mary Ida Snyder</b>				2a. DATE OF DEATH MONTH <b>11</b> DAY <b>25</b> YEAR <b>85</b>				2b. HOUR <b>3:35</b> AM	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH <b>October</b> DAY <b>11</b> YEAR <b>1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>restaurant</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Alfred</b> MIDDLE <b>B.</b> LAST <b>Mazingo</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Lena</b> MIDDLE <b>F.</b> LAST <b></b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-12-0456</b>		17. INFORMANT ADDRESS <b>Ronald E. Kershner, LaVale, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC BREAST AND LUNG CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>EXTREME CACHEXIA.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>FEW SECS.</b> <b>4 MONTHS.</b> <b>2 MONTHS.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>									
19a. DATE OF OPERATION <b>X</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>X</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11. 19</b> , 19 <b>85</b> , to <b>11. 25</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>11. 24</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>M. Shafi</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11/25/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SHAFI.</b>				22e. ADDRESS <b>WASHINGTON COUNTY HOSPITAL</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>Nov. 27, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Hagerstown, Wash., Maryland</b> COUNTY <b></b> STATE <b></b>			
24. FUNERAL DIRECTOR NAME <b>MINNICH FUNERAL HOME</b> ADDRESS <b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 29 1985</b>		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

11 2 20 21

120758

120758

120758

120758

120758

120758

120758

120758

326095

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Charles Jeremiah Startzman</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11 13 85</i>		2b. HOUR <i>9:00 a.m.</i>
3. SEX <i>Male</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>1 28 07</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>78</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD		
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>self employed</i>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>MD</i>	13b. COUNTY <i>Washington</i>	13c. CITY OR TOWN <i>Hagerstown</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>Linwood Rd Ext 21740</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles A. Startzman</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary J. Collins</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>220-283818A</i>		17. INFORMANT <i>Edna B. Startzman Hagerstown, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>25 minutes</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e) <i>Adenocarcinoma of the Colon with Intussusception, acutely</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		22c. DATE SIGNED <i>11/15/85</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr Robert Baull</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>November 16, 1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rose Hill Cemetery</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown Washington Md.</i>		24. FUNERAL DIRECTOR NAME ADDRESS <i>MINNICH FUNERAL HOME 415 E. Wilson Blvd. Hagerstown, Maryland 21740</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 20 1985</i>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of report.



326035



20

319002

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BELVA LLEWELLYN STITELY</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11/09/85</b>		2b. HOUR <b>8:30PM</b>	
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH DAY MONTH YEAR <b>10/08/94</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b>	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON</b>		10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>COLTON VILLA NURSING HOME</b>		12a. USUAL OCCUPATION <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
13a. STATE <b>WASHINGTON</b>					
14. FATHER'S NAME <b>LITTLETON CLARENCE FOX</b>					
15. MOTHER'S MAIDEN NAME <b>ZELPHIA C. RAMSBURG</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					
16b. SOCIAL SECURITY NO. <b>212-72-5164</b>					
17. INFORMANT <b>MARGUERITE L. BAKER</b>					
18. ADDRESS <b>12331 OLD FREDERICK RD. Thurmont, Md</b>					
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Q. O. O. O.</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/10/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ABDUL WATHEED, MD</b>		22e. ADDRESS <b>1610 - OAK HILL AVE. HAG, MD 21740</b>			
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>11/12/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. HOPE CEMETERY</b>	
23d. LOCATION <b>WOODSBORO</b>		COUNTY <b>Frederick</b>		STATE <b>Md</b>	
24. FUNERAL DIRECTOR <b>D. D. HARTZLER</b>		WOODSBORO		25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1985</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 96 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

313002

11/02/82

STREET

WILLOW

11/02/82

11

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82

11/02/82



312033

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <i>Charles Samuel Stouffer</i>			2a. DATE OF DEATH MONTH <i>11</i> DAY <i>3</i> YEAR <i>FR</i> 10 <sup>AM</sup>		2b. HOUR
3 SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH MONTH <i>December</i> DAY <i>26</i> YEAR <i>1910</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>74</i> YRS.	IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.	
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>railroad</i>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Washington</i>	13c. CITY OR TOWN <i>Hagerstown</i>	13e. STREET ADDRESS / ZIP CODE <i>Route 9, Box 325 21740</i>		
14. FATHER'S NAME FIRST <i>Charles</i> MIDDLE <i></i> LAST <i>Stouffer</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Katie</i> MIDDLE <i></i> LAST <i>Beitler</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>705-10-5466</i>		17. INFORMANT <i>Goldie M. Stouffer, Hagerstown, Md.</i>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary artery disease.</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i></i> P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <i>11/1</i> , 19 <i>85</i> , to <i>11/3</i> , 19 <i>85</i> , then (1) (we) last saw the deceased alive on <i>11/3</i> , 19 <i>85</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did not) view the body after death.					
22b. SIGNATURE <i>Alfred D. H. M.D.</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>11/3/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Alfred D. H. M.D.</i>		22e. ADDRESS <i>1610 Oak Hill Ave. Hagerstown MD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b. DATE <i>Nov. 6, 1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>	
23d. LOCATION CITY OR TOWN <i>Hagerstown, Wash., Maryland</i>		23e. COUNTY <i>Maryland</i>			
24. FUNERAL DIRECTOR NAME <i>MINNICH FUNERAL HOME</i>		ADDRESS <i>415 E. Wilson Blvd., Hagerstown, Md. 21740</i>		25a. DATE OF DEATH <i>NOV 06 1985</i>	
25b. REGISTRAR'S SIGNATURE					

3405E



325116

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 104 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ROBERT</b> <b>West</b> <b>SWARTZ</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 13 1985</b>			2b. HOUR <b>12:25 P.M.</b>				
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>September 14, 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.				
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN ABOVE FACILITY, GIVE STREET ADDRESS) <b>Coffman Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>none</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>813 Frederick St. 21740</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Oscar Swartz</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mabel Mae Grubb</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Irene Swartz, Hagerstown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis, generalized</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5m</b> <b>year</b> <b>year</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Emphysema</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 1, 1980</b> to <b>Nov 12, 1985</b> , that (I) (we) last saw the deceased alive on <b>Nov 12, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										
22b. SIGNATURE <b>L L Packard Jr</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/23/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>L L Packard Jr, MD</b>			22e. ADDRESS <b>Hagerstown, Md 21740</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>			23b. DATE <b>Nov. 15, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 18 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

BP

November 19 1985 10:52

STANDARD

STANDARD

Continued from

Hypothetical

There is a possibility  
that the body is not  
the same as the one  
found in the car.

There is a possibility  
that the body is not  
the same as the one  
found in the car.

There is a possibility  
that the body is not  
the same as the one  
found in the car.



325109

DIVISION OF VITAL RECORDS, 201 WEST PRESTON STREET, BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE RECORDED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 WEST PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		7d. HOUR	
ELMER BROWNING TAYLOR								X Nov. 4 1985								6:55 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		7d. HOUR	
Male	White	May 21 1917		68 YRS.				NOVEMBER 4 1985								7:45 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH										MD	
Virginia		USA				WASHINGTON											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Hagerstown		Washington County Hospital		Ret. Laborer		Construction											
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		42 Washington Street								21740	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Theodore		Taylor		Ella		Knight											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		W.W.II		234-22-6905		Mrs. Sandra Wells		P.O. Box 1506		Winchester, VA		22601					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) #427 - CARDIAC ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
				DOE TO, OR AS A CONSEQUENCE OF													
				(b) #402 - HYPERTENSIVE CARDIOVASCULAR DISEASE		10-15 YRS.											
				DOE TO, OR AS A CONSEQUENCE OF													
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1		#303 - ACUTE & CHRONIC ALCOHOLISM - (MANY YEARS)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
				STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		EDWARD W. DITTO, III, M.D.		TITLE (SPECIFY)		DEPUTY		MEDICAL EXAMINER		DATE SIGNED		Nov. 5, 1985					
EXAMINER'S NAME (TYPE OR PRINT)		EDWARD W. DITTO, III, M.D.		ADDRESS		217 WEST WASHINGTON STREET		HAGERSTOWN, MARYLAND		21740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE							
Burial		Nov. 8, 1985		New Norborne Cemetery		Martinsburg		Berkeley		WV							
24. FUNERAL DIRECTOR		Charles M. Brown		ADDRESS		327 W. King St		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Brown Funeral Home		PO Box 821, Martinsburg, WV															

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

352103

WASHINGTON

100 - ARCADE STREET

100 - REPRESENTATIVE CARPENTARY LUMBER

100 - ADULT & CHILDREN'S RECEPTION - (MAY YEAR)

EDWARD W. LITTO, III, W.F.  
AGRESTON, ARYLAND 2100  
27 WEST WASHINGTON STREET  
CHUTY

329044

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR			
MIGUEL ANEGEL VILLEGAS, SR.						11 17 1985						M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR	
male		P.R.		Sept. 20, 1957		28 YRS.						11 17 1985		10:35 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Puerto Rico				U.S.A.								Washington County MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown				Washington Co. Hospital				Laborer							
13a. STATE				13b. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
Pennsylvania				Adams				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				1365 Red Hill Road 17350			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
Saturnino Villegas				Virginia Escribano											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
No				528 25 5826				Maria A. Ponce				1635 Old Carlisle Road Aspers, PA. 17304			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
								STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
				M.D. Assistant				11-18-85							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Ann M. Dixon, M.D.				111 Penn St., Balto., MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Burial				11/23/1985		Caguas Cemetery				Caguas, Puerto Rico					
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Burgee-Henss Funeral Home, Baltimore, Md. 21211								NOV 21 1985							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84

BP

FORM 17  
(R 4/5 ME (5))

MOESC

333063

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the death certificate is filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Hazel Louise Welch</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 15, 1985</b>			2b. HOUR M				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 4, 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Route # 3 Garis Shop Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Route # 3 Box 317-B</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ernest F. Fogle</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Grace Martin</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>215-14-2524</b>		17. INFORMANT ADDRESS <b>Linda Jo Campbell Rt. #9 Box 272 Hagerstown, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Related ventricular obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Underlying</u> <u>hypertension of stage IV</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>None</u>										
19a. DATE OF OPERATION <b>6/28/85</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Vaginal bleeding</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>239 N. POTOMAC ST. HAGERSTOWN, MD. 21740</b>						
22a. I certify that (1) <u>the hospital</u> attended the deceased from <u>6/25</u> 19 <u>85</u> , to <u>11/5</u> 19 <u>85</u> , that (1) <u>was</u> last saw the deceased alive on <u>11/5</u> 19 <u>85</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>was</u> (did) not view the body after death.										
22b. SIGNATURE <u>John R. Marsh, M.D.</u> DEGREE <u>M.D.</u>						22c. DATE SIGNED <u>11/19/85</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOHN R. MARSH, M.D.</u>						22e. ADDRESS <u>239 N. POTOMAC ST. HAGERSTOWN, MD. 21740</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-19-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown Washington Md.</b>				
24. FUNERAL DIRECTOR NAME <b>A.K. Coffman Funeral Home, Inc.</b>						24. DATE OF REGISTRATION <b>NOV 22 1985</b>				

BP

000000

November 22, 1967

London, Ontario

Dear Sirs

Enclosed for you are two copies of a report on the results of the survey of the water quality of the St. Lawrence River at Montreal, Quebec, Canada.

The report is dated November 15, 1967.

Very truly yours,

Director

Enclosure

Very truly yours,

Director

Director

Enclosure

Very truly yours,

Director

Director

Enclosure

Very truly yours,

Director

Director

Enclosure

Very truly yours,

Director

Director

Enclosure

Very truly yours,

Director

Director

Enclosure

Very truly yours,

Director

Director

Enclosure

Very truly yours,

Director

Director

Enclosure

Very truly yours,

Director

Director

Enclosure

Very truly yours,

Director

Director

Enclosure

Very truly yours,

Director

Director

Enclosure

Very truly yours,

Director

Director

Enclosure

Very truly yours,

Director

Director

Enclosure

Very truly yours,

Director

Director

Enclosure

Very truly yours,

Director

Director

Enclosure

Very truly yours,

Director

Director

Enclosure

Very truly yours,

Director

Director

Enclosure

Very truly yours,

Director

Director

Enclosure

Very truly yours,

Director

Director

Enclosure

Very truly yours,

Director

Director

338134

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Catherine G White				2a. DATE OF DEATH MONTH DAY YEAR 11-25-85				2b. HOUR 355 AM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 09-13-95		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colton Villa Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laundry		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12 S. Walnut Street 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Albert Kretzer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katie Ridenour					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 219-14-7651		17. INFORMANT ADDRESS Paul White, Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>senile dementia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A. M. G. Paul						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/26/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABDUL WAHEED						22e. ADDRESS 1600 Oak Hill Ave. HAG, MD 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE Nov. 27, 1985		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland		
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME NAME ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 02 1985 John E. Wilson			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon plates for Part 1 and 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the medical examiner may be notified at once.



151238

THIRTY

20% COTTON FIBER

DOWN



Subsidiary 30 20 30

336076

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR <b>HELEN FRANCES WIEBEL</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11 - 22 - 85</b>		2b. HOUR <b>9 20 A M</b>	
1. DECEASED NAME (TYPE OR PRINT) <b>Helen Frances Wiebel</b>		3. SEX <b>Female</b>		4. RACE <b>White</b>	
5. DATE OF BIRTH MONTH DAY YEAR <b>July 2, 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Owner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>		13a. STATE <b>Maryland</b>	
13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Ellsworth Frank</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marie Edith Moore</b>		13e. STREET ADDRESS / ZIP CODE <b>203 South Prospect Street 21740</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-09-6909</b>		17. INFORMANT ADDRESS <b>Ann M. Manley 120 W. Baltimore Street Hagerstown, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>probable myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Intense Complete Heart Block</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>2 weeks</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION <b>11-9-85</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Complete Heart Block</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11-2</b> , 19 <b>85</b> , to <b>11-22</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>11-21</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John H. Hornbaker Jr.</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-22-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John H. Hornbaker Jr.</b>		22e. ADDRESS <b>645 E. First St., Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-25-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery Hagerstown, Washington, Md.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Md.</b>		24. FUNERAL DIRECTOR NAME <b>A.K. Coffman Funeral Home, Inc.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1985</b>	
25b. REGISTRAR'S SIGNATURE					

DHMH - 16 60M 7/84

(VRA 15, 4)

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

336076

11-22-82 120

Handwritten notes and stamps, including a circular seal with the number 15.

11-22-82 120

Handwritten notes and stamps, including a circular seal with the number 15.

Handwritten notes and stamps, including a circular seal with the number 15.

Handwritten notes and stamps, including a circular seal with the number 15.

Handwritten notes and stamps, including a circular seal with the number 15.

Handwritten notes and stamps, including a circular seal with the number 15.

Handwritten notes and stamps, including a circular seal with the number 15.

Handwritten notes and stamps, including a circular seal with the number 15.

Handwritten notes and stamps, including a circular seal with the number 15.

Handwritten notes and stamps, including a circular seal with the number 15.

Handwritten notes and stamps, including a circular seal with the number 15.

Handwritten notes and stamps, including a circular seal with the number 15.

Handwritten notes and stamps, including a circular seal with the number 15.

Handwritten notes and stamps, including a circular seal with the number 15.

Handwritten notes and stamps, including a circular seal with the number 15.

Handwritten notes and stamps, including a circular seal with the number 15.

Handwritten notes and stamps, including a circular seal with the number 15.

Handwritten notes and stamps, including a circular seal with the number 15.

Handwritten notes and stamps, including a circular seal with the number 15.

338052

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST Elizabeth LAST NANCY F. WILSON		2a. DATE OF DEATH MONTH DAY YEAR 11/26/85		2b. HOUR 2:40pm	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR October 11, 1924	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. AGE (IN YEARS LAST BIRTHDAY) 61 YEARS MONTHS DAYS	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WESTERN MARYLAND CENTER		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none		12b. KIND OF BUSINESS OR INDUSTRY none			
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2225 Bonnie Briar Lane 21740			
14. FATHER'S NAME FIRST Charles A. Snider MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE LAST Sellers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No		16b. SOCIAL SECURITY NO. 201-16-4106		17. INFORMANT ADDRESS Dr. John Wilson, Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>11/18</u> , 19 <u>85</u> , to <u>11/26</u> , 19 <u>85</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>11/26</u> , 19 <u>85</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> view the body after death.					
22b. SIGNATURE <u>Rose Marie Chan, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>11/26/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROSE MARIE CHAN</u>		22e. ADDRESS <u>Western Maryland Center, Hagerstown, MD 21740</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Dec. 1, 1985		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park	
23d. LOCATION CITY OR TOWN Hagerstown, Wash., Md.		23e. COUNTY MD		23f. STATE 21740	
24. FUNERAL DIRECTOR NAME 415 E. Wilson Blvd., Hagerstown, Md. 21740		MINNICH FUNERAL HOME ADDRESS		25a. DATE REC'D. BY REGISTRAR DEC 2 1985	
		25b. REGISTRAR'S SIGNATURE			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the completed pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

529258

340025

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joyce M. WISHARD		2a. DATE OF DEATH MONTH DAY YEAR Nov. 27, 1985		2b. HOUR M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 16 1926		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Crossing Guard Bd. Of Ed.		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 648 W. Washington St. 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Earl Yeakle		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Seibert			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 227-34-0511		17. INFORMANT Robert R. Wishard same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) MITRAL + AORTIC VALVULAR DIS. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Renal Failure; Malnutrition					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) G.C.		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11. 27. 35	
22a. I certify that (I) (this hospital) attended the deceased from 6. 6. 19 35 to 11. 27. 19 85, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Otto Roza		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11. 28. 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Otto Roza MD		22e. ADDRESS 100 Lohmeyer Ave., Hagerstown MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-30-85		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Pl.	
23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Wash Md.		24. FUNERAL DIRECTOR NAME Gerald N. Minnich Hagerstown, Maryland			
25a. DATE REC'D. BY REGISTRAR 4-1985		25b. REGISTRAR'S SIGNATURE John J. Anderson			

340022

26% COL ON EIPERS

10/10/11

10/10/11





343092

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Robert H. Woodring</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 27, 1985</b>			2b. HOUR <b>3 P.</b> M.				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 3, 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b> <b>Waynesboro</b>		
13a. STATE <b>Pennsylvania</b>			13b. COUNTY <b>Franklin</b>		13c. CITY OR TOWN <b>Waynesboro</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>208 Roadside Ave. 99999</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles W. Woodring</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice Potter Bowers</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>197-100-400</b>		17. INFORMANT ADDRESS <b>Evelyn B. Woodring, 208 Roadside Ave. 17268</b> <b>Waynesboro, PA.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of thyroid with</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary metastases</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/25/85</b> to <b>11/27/85</b> , that (I) (we) last saw the deceased alive on <b>11/27/85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Frederic H. Kass III</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11/27/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS <b>1825 Itwell Rd Hagerstown Md</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Dec. 1, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Mem. Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Chambersburg, PA. Franklin Co</b>			
24. FUNERAL DIRECTOR NAME <b>Swigler Funeral Home</b>				ADDRESS <b>Waynesboro Pa</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 3 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John A. Riddle</b>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THEY ARE ALL

316016

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR										32074	
1. DECEASED NAME (TYPE OR PRINT) <b>Walter Lee Woodside</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> <b>NOV 25 1985</b>	
3. SEX <b>male</b> 4. RACE <b>white</b> 5. DATE OF BIRTH <b>March 4, 1930</b> 6. AGE (IN YEARS) <b>55 YRS.</b> 7. IF UNDER 1 YR. <b>MONTHS</b> <b>DAYS</b> 8. IF UNDER 24 HRS. <b>HOURS</b> <b>MIN.</b>										2b. HOUR <b>??</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b> 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										2c. DATE PRONOUNCED DEAD <b>Dec. 2 1985</b> 2d. HOUR <b>8:10</b>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b>										MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>14 Brightwood Drive</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>auditor</b> 12b. KIND OF BUSINESS OR INDUSTRY <b>hotel</b>											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Washington</b> 13c. CITY OR TOWN <b>Hagerstown</b> 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO 13e. STREET ADDRESS <b>14 Brightwood Dr. 21740</b>											
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Grant E. Woodside, Sr.</b> 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Mary E. Little</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>Air Force</b> 16b. SOCIAL SECURITY NO. 17. INFORMANT <b>Grant E. Woodside, Sr.</b> ADDRESS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>#263 - MALNUTRITION</b> (b) <b>DUE TO, OR AS A CONSEQUENCE OF</b> (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SEVERAL MOS.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Edward W. Ditto</b> M.D. TITLE (SPECIFY) <b>DEPUTY</b> MEDICAL EXAMINER DATE SIGNED <b>Dec. 3, 1985</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>EDWARD W. DITTO, III, M.D.</b> ADDRESS <b>217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b> 23b. DATE <b>Dec. 4, 1985</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Mem. Park</b> 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Williamsport, Wash., Maryland</b>											
24. FUNERAL DIRECTOR (NAME ADDRESS) <b>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</b> 25a. DATE REC'D. BY REGISTRAR <b>DEC 6 1985</b> 25b. REGISTRAR'S SIGNATURE <b>John E. ...</b>											

310010

11 25 1942

11 25 1942

ON JAN 25

NOTIFICATION - 1942

11 25 1942

11 25 1942

11 25 1942

11 25 1942

11 25 1942

ON JAN 25

ON JAN 25

322095

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATHFOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ALBERTA F Zeigler</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-8-85</b>		2b. HOUR M <b>3pm</b>
3. SEX <b>F</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5 30 26</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Boonsboro, Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MD</b>		13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Boonsboro</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>8 Knode Circle 21713</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albertus Daniel Mullendore</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances Young Alexander</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-20-1880</b>		17. INFORMANT ADDRESS <b>Richard E. Zeigler, 8 Knode Circle Boonsboro, Md. 21713</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIO MYOPATHY</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute Myelitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Pneumonia</b>					
19a. DATE OF OPERATION <b>10-38-85</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PNEUMONIC PNEUMONITIS</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>11. 1984 11. 8 1985</b>	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <b>8-11-85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Otto Rora</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11. 8. 85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Otto Rora MD</b>		22e. ADDRESS <b>100 LOWMEAD DR DR HAGERSTOWN MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-11-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Middletown, Fred. Co., Md.</b>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>NOV 14 1985</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>John H. Bast, Jr. Boonsboro, Md. 21713</b>					

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000



100-100000

100-100000

100-100000

100-100000

333048

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as soon as possible.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Elizabeth H. Zimmerman		2a. DATE OF DEATH MONTH DAY YEAR 11-17-85	
3. SEX female		4. RACE white	
5. DATE OF BIRTH MONTH DAY YEAR August 7, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garlock Memorial Home	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) cook		12b. KIND OF BUSINESS OR INDUSTRY restaurant	
13a. STATE Maryland		13b. COUNTY Washington	
13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 563 Salem Avenue 21740			
14. FATHER'S NAME FIRST MIDDLE LAST Jackson Campbell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-16-1769	
17. INFORMANT Charles Zimmerman, Williamsport, Md.		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause and line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Longer both legs due to occlusion arterial disease DUE TO OR AS A CONSEQUENCE OF DUE TO OR AS A CONSEQUENCE OF Arterio-sclerotic heart disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pork Choker - Vascular Accident			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/7 1979, to 11/17 1985, that (I) (we) last saw the deceased alive on 11/16/1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Sidney Novemstein MD		22c. DATE SIGNED 11-18-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SIDNEY NOVENSTEIN MD		22e. ADDRESS 20150 W. MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Nov. 19, 1985	
23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR NOV 21 1985	
415 E. Wilson Blvd., Hagerstown, Md. 21740		REGISTRAR'S SIGNATURE John Davidson-Randall	

BP



88308

11-17-82 Mrs. [illegible]

[Faint, illegible text]

[Faint, illegible text]

[Faint, illegible text]

[Faint, illegible text]

[Faint, illegible text]

m. Park

BOX-COTTON L  
FALLEN